99-72

MEDICARE REIMBURSEMENT FOR CAPITAL EXPENSES

5

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

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MEDICARE REIMBURSEMENT FOR CAPITAL EXPENSES

MONDAY, FEBRUARY 24, 1986

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 1:05 p.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[For immediate release Wednesday, Feb. 5, 1986]

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON A NEW MEDICARE REIMBURSEMENT MECHANISM FOR CAPITAL COSTS TO BE HELD ON MONDAY, FEBRUARY 24, 1986

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee on Health will hold a hearing on proposals for including hospital capital costs in the medicare prospective payment system. The existing mechanism expires on October 1, 1986. The hearing will be held on Monday, February 24, 1986, at 1:00 p.m., in the Committee's Main Hearing room, 1100 Longworth House Office Building.

"We hope to come up with a plan that will provide adequate funds for hospitals to maintain their physical plant and equipment at the level patients have come to expect . . ." said Chairman Stark.

Under existing law, medicare reimburses capital costs on a reasonable cost basis. When Congress enacted the prospective payment system, which makes a fixed payment per illness, it required the Department of Health and Human Services to develop recommendations by October 1984 on how to incorporate capital payments into the prospective payment system. The HHS legislative recommendations have not yet been submitted.

Over the last several years there has been substantial discussion of this issue. Some suggest that hospital capital payments should be made on the basis of a flat percentage add-on to the existing DRG prospective payment rate. Others suggest that the current reasonable cost based system should be retained but subjected to more comprehensive health planning review.

The Administration's FY 1987 budget contains a regulatory proposal which would incorporate payment for capital costs into the prospective payment system over the next four years. When this system is fully implemented, a fixed payment that includes both capital and operating costs would be made for each medicare admission.

Chairman Stark said, however, that he believes that the Congress should act on any such major change.

Chairman Stark invites witnesses to comment on the Administration's regulatory proposal and other proposals that could lead to the development of an equitable method for incorporating capital into the prospective payment system.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler [(202) 225-3627] no later than close of business Monday, February 17, 1986, to be followed by a formal written request to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The Subcommittee staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the Subcommittee office [(202) 225-7785].

In view of the limited time available to hear witnesses, the Subcommittee may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance will be encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline. Preference will be given to individual institutions willing to provide hard financial data and discuss specifically how the various capital options will impact their institutions. Specifically, the institutions would be asked to provide information which details its total revenues compared to its total cost of operations.

It is urged that persons and organizations having a common position make every effort to designate one spokesman to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. This process will afford more time for members to question witnesses. In addition, witnesses may be grouped into panels with strict time limitations for each panelist.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses invited to appear before the Subcommittee are asked to comply with the following requirements:

1. Witnesses should submit 100 copies of their written statement to the Health Subcommittee, 1114 Longworth House Office Building, by noon on Friday, February 21, 1986.

2. Each statement to be presented to the Subcommittee or any written statement submitted for the record should contain the following:

a. The name, full address, and capacity in which the witness will appear (as well as a telephone number where the witness or a designated representative may be reached);

b. A list of any clients or persons, or any organization for whom the witness appears; and

c. A topical outline or summary of comments and recommendations.

3. Witnesses should not read their written statements to the Subcommittee, but should instead limit their oral presentations to a summary of the points included in the statement. Witnesses are requested to limit their oral summaries to no more than five minutes.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and must be submitted by the close of business on Friday, March 14, 1986, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. (See other requirements under #2 above.) An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

Chairman STARK. The committee will proceed.

Our topic today is a complex question involved in Medicare reimbursement, to oversimplify what we are talking about, the relationship between medicine and the moneylenders, or to be specific, how the Government should reimburse hospitals for their capital costs.

For the thousands of hospitals already within the prospective payment system, this is the last frontier. We have put them on

notice that Medicare will give them a set price for the DRG, and this puts pressure on the hospitals to become more efficient.

When we voted for PPS in 1983 we excluded capital from the general payments because of technical questions we didn't then know how to answer.

Instead we continued to pay costs that didn't give hospitals much incentive to make sound investment decisions. Now it is time to find a new way to pay for capital and our goal today is to find answers to those questions that we had back in 1983.

We need a long-term and a short-term answer. For the long-term we must create a new system that will give hospitals incentives to hold costs down but also include a transition that is generous enough to keep them alive while the long-term solution is being phased in.

Crafting a transition rule won't be an easy job. The answer to our questions may determine whether some hospitals continue to exist. There may be a question as to whether or not some hospitals should continue to exist.

It is an issue that merits congressional attention we feel, and cannot be left solely to a bureaucratic rule making. I say that not in the pejorative sense with respect to our first witness but because I think the legislative process can perhaps be more comprehensive than the normal 30-day time for response to rules published in the Federal Register.

In addition to witnesses from the administration we will soon hear from the General Accounting Office—we have asked them to look into this question and hope to receive a copy of their report in the near future.

I have asked today's witnesses, with the exception of the first two, to focus on specific facts rather than theory and general philosophy and provide us with specific financial data relative to their specific and individual institutions.

If they have hard data and anecdotal data, I think it would be a lot easier for this committee to try resolve the problems that may be created.

I see this—and I speak as an individual—as a shift or another part of the shift from cost-plus fee type of purchasing, to bidding on a fixed price basis.

While there has been a lot of debate as to whether we should go to the historic cost or PPS, I think our entire subcommittee would agree we cannot have both. We cannot sit here with one shoe off and one shoe on. For better or for worse, the country is going to a PPS system and all costs provided in medical care will have to be included, including capital.

I think with the help of the administration witnesses and the advocacy groups, this committee will be able to find a compromise that will be best for the industry.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I want to particularly express my appreciation to you for calling a hearing on this subject, as the No. 1 and first subject to be undertaken by the subcommittee this year.

I think that fact highlights the importance with which all of us on the subcommittee attach to this particular issue. Indeed it is an

issue that we have attached importance to for a long time. Back in 1983, almost 3 full years ago, we passed a law which was signed by the President which directs the Secretary of HHS to study, develop and report to Congress within 18 months on the method and proposals for legislation by which capital costs can be included within the prospective payment amounts.

That was 3 years ago.

We have been waiting, we are still waiting, and I think we have waited long enough.

I think the very delay, for which this committee is certainly not responsible, has put in a very exposed position a great many hospitals around the country. It has been common knowledge for a long time that something was likely to be done about capital on October 1, 1986. Until a few months ago, I think it was generally accepted that whatever would be done for better or worse, was going to be done by the Congress.

Now we are facing not only October 1, which isn't far off, but a naked assertion of power on the part of the executive branch having delayed its report to go ahead and do it on its own.

I am concerned about this, Mr. Chairman, because I don't think we can look at the hospital industry in a macro sense. We have to be concerned, as I am sure many of the witnesses will be, about how it affects particular institutions. Will they be able to pay their debt? Will hospitals continue to have access to the credit markets, not just the ones which may have trouble paying bonds they have issued already, but others that could be affected with broad brush if it looks like hospital boards are beginning to default and institutions are beginning to fail.

I also think even if an environment where one must wonder whether all the hospitals are going to be necessary to meet the public health needs in the future, whether we want to create a situation in which the institutions likely to be at greatest risk are the newest and most modern institutions, that is those that have undertaken to borrow substantial amounts of money, and in other ways raise capital to update their facilities.

So, Mr. Chairman, I know we share many if not all of these concerns, I think all of these concerns, and I look forward as you do to hearing from our witnesses on these very vital issues.

Chairman STARK. Thank you very much.

Mr. Pickle.

Mr. PICKLE. No, Mr. Chairman. Thank you. I am looking forward to the testimony. Thank you.

Chairman STARK. All right; I am happy to welcome Dr. Robert Helms, the Acting Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services.

Dr. Helms, I would like you to introduce the gentlemen accompanying you and let you present in any manner you are comfortable.

Welcome to the committee.

STATEMENT OF ROBERT HELMS, PH.D., ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY RANDY TEACH, DIRECTOR OF HEALTH POLICY; JANET WEINGART; AND TOM AULT, HEALTH CARE FINANCING ADMINISTRATION

Mr. HELMS. Thank you.

With me is Randy Teach, Director of Health Policy; assisting me with the charts is Janet Weingart; and Tom Ault from the Health Care Financing Administration is also here.

It is a pleasure to appear before you to discuss payment for capital-related expenses for inpatient hospital care. As you know, Congress in the Social Security Amendments of 1983 decided to exclude capital-related expenses from the prospective payment system until October 1986 and directed the Department to study ways that capital might be incorporated into the prospective payment.

The administration's policy is an outgrowth of our study effort. I have appended to my opening remarks, one, an outline of the Department's proposed method of incorporating capital expenses into the prospective payment system; two, a rationale for the proposed method; and three, as requested by this committee, a justification for our intention to implement this policy. This course of action is consistent with Congressional Research Service interpretation of Public Law 98-21 and the accompanying conference committee report. We will be pleased to work with your staff, as we have in the past, with the development of your own proposals in this area.

I don't intend to read the statement, but will go through a set of charts which will facilitate the explanation, I believe.

If I might, I would like to proceed. Copies of the charts—I will try to refer to the numbers for the people who cannot see them—are attached to the statement.

Chairman STARK. Without objection, the copies of the charts will be incorporated in the record.

Mr. HELMS. We have decided on, and recommend to you, a system of incorporating capital payments amounts into the nonlabor portion of the PPS standardized amounts. What this means then is an averaging system.

Just to review how we currently calculate the PPS rates—and this is simplified here—for the operating costs: we now take the labor portion and adjust it by the wage index, add in nonlabor portion not including capital now, and compute urban and rural standardized amounts that are adjusted by the DRG weights to determine the payment to the hospital.

Chairman STARK. Can I stop you there a minute and see if I understand, Mr. Helms?

Let's take for better or worse an appendectomy. That standardized amount is just kind of an index number to which, say, the appendectomy would be—if it comes out to $1,000 for an urban hospital, then any procedure is a percentage of that standardized amount, is that how we get to the payment to the hospital?

Mr. HELMS. As I understand it, the standardized amounts are really computed on the basis of a standardized cost per discharge; the cost of an appendectomy is determined on its costs relative to

the cost of all other procedures; so this standardized amount is adjusted for each DRG to reflect the cost.

Chairman STARK. As a percentage.

Mr. HELMS. It is an index number system, yes, which ups the standardized amount by a certain percent if the DRG weight for that particular amount is greater than the average.

Chairman STARK. OK.

Mr. PICKLE. Let's simplify further, if the chairman wouldn't mind.

Give us an example so we have a better idea of what you are floating past us, can you do that, a simpler one?

Mr. HELMS. I think if——

Mr. PICKLE. I am just trying to find out, you've got your labor portion, wage index and you compare that with the nonlabor portion, then you arrive at some amount. Give me an example of that. Say it is an appendectomy.

Mr. HELMS. I don't know the actual figures but, first of all, the capital expenditure is around 8 percent of the operating cost. So we are talking about adding less than 10 percent onto this amount.

Just on the operating cost side, the biggest part of this—around 70 percent approximately—is the labor portion. Then you have another 20-some percent like supplies and so on that go into that.

So if an urban standardized amount were $500 you are talking about the cost that went into producing the discharge for that particular hospital, and then the DRG is a separate index number system which adjusts the standardized amount considering whether the cost of an appendectomy is more or less than the average.

Hospitals which have all serious cases, meaning all DRG's which are relatively expensive, will get more money than other hospitals.

Mr. PICKLE. Mr. Chairman, I am going to request that we ask the Department to give us some examples of each one of these charts as we go along. It is hard for me to understand how the formula works. It is a bit of gobbledygook for a person not really following it to stay that close. I am going to ask that you do that now or as you follow through.

Mr. HELMS. We do have those examples, yes.

[The information follows:]

In general terms, the formula which determines a hospital's prospective payment is:

Payment per discharge = DRG weight × Standardized Amount

A hypothetical example of a payment calculation is provided in the April 1985 Report of the Prospective Payment Assessment Commission; a copy of that table is enclosed. Although this particular table is applicable to 1985, when the Federal-hospital specific split was 25–75, the step-by-step process is the same.

Table A-1.—Example Of Calculation Of PPS Payment

Hypothetical Hospital located in Chicago, Illinois:

- Beds = 300
- Interns & Residents = 30
- Wage index = 1.2240
- Case-mix index = 1.08
- Hospital-Specific Cost/Case in base year = $3,200
  (Fiscal year starts July 1; base year: July 1, 1982 to June 30, 1983)

Hypothetical Case:

- DRG 235 (Fracture of femur)
- Discharged on January 15, 1985
- Weight = 1.7403

1. Calculation of Hospital Specific Portion:
   Update cost/case to FY 84:
   $3,200/1.08 × (1.12701) = $3,339.29
   Update cost/case to FY 85:
   $3,339.29 × (1.06300) = $3,549.66
   Multiply times DRG weight:
   $3,549.66 × $1.7403 = $6,177.48

2. Calculation of Federal Portion (which is 75% Regional and 25% National):
   - Regional urban standardized amount =
     $2,452.00 labor related; $712.68 nonlabor related
   - National urban standardized amount =
     $2,320.61 labor related; $664.44 nonlabor related

   Regional: ($2,452.00 × 1.2240) + $712.68 = $3,713.93
   National: ($2,320.61 × 1.2240) + $664.44 = $3,504.87
   (0.75 × $3,713.93) + (0.25 × $3,504.87) = $3,557.13
   Multiply times DRG weight:
   $3,557.13 × 1.7403 = $6,057.79

   Indirect teaching allowance*
   - Scaling factor = 0.1
   - Teaching adjustment factor = 0.1159
     (Interns and Residents)/beds/0.1 × 0.1159 × $6,057.79 =
     30/300/0.1 × 0.1159 × $6,057.79 = $702.10

   Total Federal Portion = $6,057.79 + 702.10 = $6,759.89

3. Since January 15, 1985 occurs during the hospital's first year under PPS, the formula is:
   (0.75 × Hospital-Specific + 0.25 Federal)
   (0.75 × $6,177.48) + (0.25 × $6,759.89) = $6,323.08

*Attributable to this case but paid at a later date in a lump sum payment (although the hospital receives interim payments every two weeks).

Chairman STARK. As I understand it, the standardized amount is specific to a hospital or an area depending on whether it is rural or urban, but the DRG weight is just relative to all the different 450 procedures and it is applied around the country so the standardized amount is more hospital-specific, if that is a good term, than the various weightings; is that a correct assumption?

Mr. HELMS. I think it is, yes.

What we are doing here is adding capital into this to compute this standardized amount. So it is adding this in and once the transition is over, the hospital would not distinguish between capital and operating payments. It is just a single payment per case.

The calculation that we are proposing would really consist of a national and hospital-specific rate. I will get to the hospital-specific rate later.

The national rate calculation would start with 1983 audited cost reports excluding return on equity and what is called interest offsets for funded depreciation.

These two items, ROE and IO, were designed to encourage equity financing and we think under PPS that is not appropriate anymore and in the calculation of national rates these items should be excluded.

I got ahead of myself here.

Let me back up and say that what we are really proposing to do. The advantages of our proposal are built on the criticisms of old cost-based reimbursement of capital investment. The advantages of going to our system is that it would link the payments for capital to patient volume, not to the historical asset value of the hospital.

That is the major difference in our approach. It has the advantage of directing payments from the trust fund to those hospitals which are really serving the Medicare patients.

If that patient volume changes over time, the payments follow the Medicare patients. If that happens in a local area, certain hospitals are able to attract Medicare patients, then the payment automatically goes to them. We think this encourages prudent investment, not just maximization of revenue as you have under the incentives with the cost-based system.

We also argue that it improves efficiency. It encourages the hospital manager of each hospital to make decisions about capital on the basis of the true economic productivity of that investment, not just on whether it is reimbursable under HCFA rules. We also think it eliminates the need for health planning.

Mr. GRADISON. On that point, just a specific question. How will you eliminate the need for health planning if you follow a procedure that requires a continuation of the 1122 process?

Mr. HELMS. Well, we would hope that the Congress will eliminate the 1122 process. If you do not, we intend to implement it but just how we would do that we have not worked out yet.

Mr. GRADISON. Implement what?

Mr. HELMS. The 1122 process. I am arguing here that we think going to this on a per case basis system eliminates the need for certificate of need and 1122, and we would urge Congress to repeal both of those.

If you do not repeal 1122 we will have to work out a system of State approval for making Medicare payments.

Chairman STARK. Dr. Helms, is this really not the issue where the cheese is going to bind? As I understand it prior to this, the capital investment certainly in the bricks and mortar as decided under a variety of regulations, one had to get permission to build something.

Mr. HELMS. Right.

Chairman STARK. If you got that permission you were reimbursed for it.

Mr. HELMS. Yes.

Chairman STARK. Now we are saying that is not such a good system. We shouldn't have been doing that because, and I suspect, we have too many buildings. But now we are saying if you can sell enough services or room rent to people, the PPS ought to pay for it.

The problem we seem to have is that people out there are still trying to pay for the old buildings we authorized and how do we switch from one system to the other? Isn't that the problem we are going to have?

Mr. HELMS. That is very well stated and I am sure you will hear a lot more about that as you go along this afternoon.

Chairman STARK. Are you going to tell me how to solve it as we go through the testimony?

Mr. HELMS. We think we do. We are proposing a transition which we think will provide a solution to it.

But you are right, under health planning you had a cost-based reimbursement system and the reason, if there was ever a reason for it, was that everybody had an incentive to go out and spend more so you had to have that system to keep it in check.

But the evidence, as I am sure you are aware, is that it has never really worked very well.

Now, back to this chart.

To compute the national rate we start with the 1983 audited cost reports and exclude return on equity and interest offsets. Why 1983? For one, Congress provided its warning in 1983, the capital addressed to this after that point may be treated differently and also it is the latest audited cost reports we have to be able to do that.

We take this 1983 audited amount and we have to update it to 1986 and there are two ways we can do that. We can update it with a market basket meaning a price index for capital, or we can do it on the basis of capital expenditures, the total amount of expenditures. The capital expenditures have been going up around 14, 15, 16 percent per year for several years historically, as shown here in this chart. Percent changes are plotted in the red for capital expenses. As you see, they have been going up at a very high percentage rate above 15 percent, 16 or 17 percent in here, particularly since 1981 they have been going up at a time when the occupancy rate, the green line, since 1980, has started down and when PPS came in in 1983 it really went down.

Here we have an industry generally characterized as having excess capacity and we have occupancy rates going down and at the same time, capital expenditures are maintained at a very high rate. So we are deliberately selecting the capital component of the market basket which will be a price index to update from 1983 to 1986.

After 1986 when we start this capital procedure, we would update thereafter by the PPS update factor determined by the Secretary.

Chairman STARK. Do you want to give us a hint of just what you think that would be over the next few years?

Mr. HELMS. No, I wouldn't.

But the Congress has limited that to the market basket plus a quarter. I can say we are also proposing that the market basket include these components for capital so that the Secretary would consider the capital needs of hospitals when making that decision.

Now, let's get to, as you say, the nub of the question, I think in your opening comments you said this is a tough problem of how to transition into this.

Of course what I have described is really the system you would have after the transition is over.

We are proposing a 4-year even blend for the major part of the capital payments for depreciation and interest, and a 3-year phase out of return on equity and interest offsets for the hospital-specific portion.

Now, remember, this would be the amount that would be paid to each individual hospital based on its cost reports and it is designed so that as the hospital-specific amount declines over the 4 years, 80, 60, 40, 20, the national rate—that amount we put on to the DRG rate increases by 20, 40, 60, 80. By the 5th year you are out of the transition.

Mr. GRADISON. In your general statement a moment ago, you said something like this, that in 1983 Congress said that capital invested after 1983 would be treated differently.

The transition that you have described sounds like it would also treat capital invested before 1983 differently.

Could you tell me how that works? If I have $1 million that I owe and capital committed in 1980 that I have not paid off, is it folded into this or does it continue to be handled on an institution-specific basis until it is paid off with this formula applying to capital committed after 1983 only?

Mr. HELMS. No. The hospital-specific portion ends after fiscal year 1990. So in October 1990 we would not tie payments directly to those past commitments.

Mr. GRADISON. I would just like to observe that that is not in my opinion consistent with the statement you made a moment ago that you interpret that what Congress was saying in 1983, and I wrote down your words, was that capital invested after 1983 would be treated differently.

I suppose that meant differently from before 1983. You are treating them the same here? Aren't you? After 1983 and before 1983? Aren't they the same in this formula?

Mr. HELMS. I suppose in the way you are looking at it, but, yes, to get this phased out we are saying that for those old commitments we would not pay anything on a hospital-specific basis but at the same time that amount of money has now been shifted and put into the DRG system.

So an individual hospital doesn't have a claim on that in the sense that they have an obligation before 1983 anymore.

Mr. GRADISON. All right.

Chairman STARK. Go ahead.

Mr. HELMS. We are proposing to set the hospital-specific amount on the 1986 cost reports, and we would update that with a capital index afterward. So the question is, why pick this 1986 amount? And why pick a 4-year period? I want to try to illustrate here if you will allow me.

We have an estimate of the dollars per discharge paid to urban and rural hospitals in 1987. We have taken the mean and those hospitals that would be 10 percent above or 10 percent below the mean. In other words, those would be the hospitals that would be relatively unaffected by this proposal.

We are showing here that all of the hospitals below this group near the mean would consist of 1,766 urban hospitals and 1,800 rural hospitals. This means that two-thirds of the urban hospitals would begin to gain from this procedure as they move toward the mean.

Chairman STARK. Excuse me, Doctor, are each of those payments, the 433, an increase in what is the first block, an increase in the standardized amount?

Mr. HELMS. That is the total payment to the hospital.

Chairman STARK. Which includes capital?

Mr. HELMS. It includes the capital amount, just the capital payments per discharge, and it includes that part which is the 80 percent, and it includes that part which is the 20 percent, 20 percent added to the national rate. That also includes the hospital specific part.

Chairman STARK. It includes labor and the wage indexing? That is the entire standardized amount?

Mr. HELMS. No. This is just the capital payments.

Chairman STARK. OK.

Mr. HELMS. We have left that other part out.

[The prepared statement and charts follow:]

Statement of Robert Helms, Ph.D, Acting Assistant Secretary for Planning and Evaluation, Department of Health and Human Services

Mr. Chairman, distinguished committee members, my name is Dr. Robert Helms and I am Acting Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services.

It is a pleasure for me to appear before you this morning to discuss payment for capital related expenses for inpatient hospital care. My office has had policy development responsibility for this issue within the Department.

As you know, Congress in the Social Security Amendments of 1983 decided to exclude capital related expenses from the prospective payment system until October 1986 and directed the Department to study ways that capital might be incorporated into the prospective system. The Administration's policy is an outgrowth of our study effort.

I have appended to my opening remarks: (1) an outline of the Department's proposed method of incorporating capital expenses into the prospective payment system; (2) a rationale for the proposed method; and (3) as requested by this Committee, a justification for our intention to implement this policy. This course of action is consistent with Congressional Research Service interpretation of P.L. 98-21 and the accompanying conference committee report. We will be pleased to work with your staff, as we have in the past, with the development of your own proposals in this area.

I do not intend to read from the statement, but provide it to the committee as background information to the chart presentation I have prepared. The charts should facilitate my explanation of the Department's proposed policy and reasons for its formulation. With your permission Mr. Chairman, I would like to proceed with the chart presentation. Copies of the charts I will use are attached to this statement.

MEDICARE PROSPECTIVE PAYMENT FOR CAPITAL RELATED EXPENSES

APPROACH:

- INCORPORATES CAPITAL PAYMENT AMOUNTS INTO THE NON-LABOR PORTION OF THE PPS STANDARDIZED AMOUNTS

NATIONAL RATE:

- 1983 AUDITED COST REPORTS EXCLUDING ROE AND IO
- UPDATE TO 1986 BY CAPITAL COMPONENT OF MARKET BASKET
- UPDATE TO 1987 AND THEREAFTER BY PPS UPDATE FACTOR

TRANSITION:

- FOUR YEAR-EVEN BLEND FOR HSP DEPRECIATION AND INTEREST
- THREE YEAR-EVEN BLEND FOR HSP ROE AND IO
- HSP FROM 1986 COST REPORTS UPDATED BY CAPITAL INDEX
- HSP PAYMENT LESSER OF COMBINED HSP AMOUNTS OR AUDITED COST REPORTS

Chart 1

PAYMENT CALCULATION

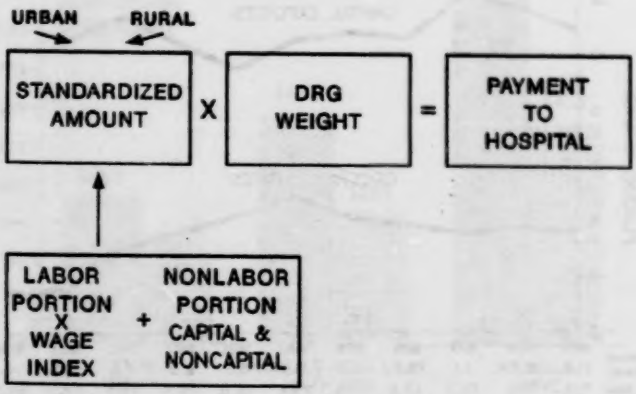


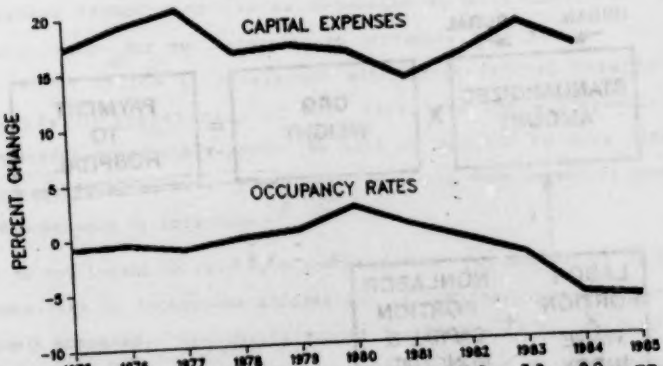
Chart 2

ADVANTAGES OF INCORPORATING CAPITAL EXPENSES INTO PPS

- LINKS PAYMENT TO PATIENT VOLUME; NOT TOTAL CAPACITY OR VALUE OF ASSETS
- ENCOURAGES PRUDENT INVESTMENT; NOT MAXAMIZATION OF REVENUE
- IMPROVES EFFICIENCY; DOES NOT ENCOURAGE SUBSTITUTION OF CAPITAL FOR LABOR
- ELIMINATES NEEDS FOR HEALTH PLANNING

Chart 3

PERCENT CHANGE IN HOSPITAL OCC. RATES AND CAPITAL EXPENSES



	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
Expenses (billions)	$1.8	2.6	3.1	3.6	4.2	4.9	5.6	6.5	7.8	9.0	--
Occ. Rate	75%	74.6	73.8	73.6	73.9	75.6	76.0	75.3	73.5	69.0	64.5

Chart 4

BLENDING PERCENTAGE FOR THE TRANSITION PERIOD

	NATIONAL RATE PORTION	HSP DEPRECIATION INTEREST PORTION	HSP RETURN ON EQUITY INTEREST OFFSET PORTION
FY 1987	20%	80%	75%
FY 1988	40%	60%	50%
FY 1989	60%	40%	25%
FY 1990	80%	20%	0%
FY 1991	100%	0%	0%

Chart 5

DISTRIBUTION OF CAPITAL PAYMENTS (1987)

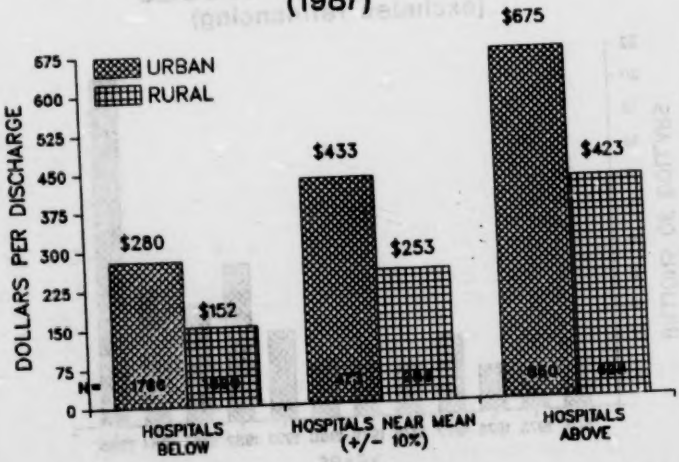


Chart 6

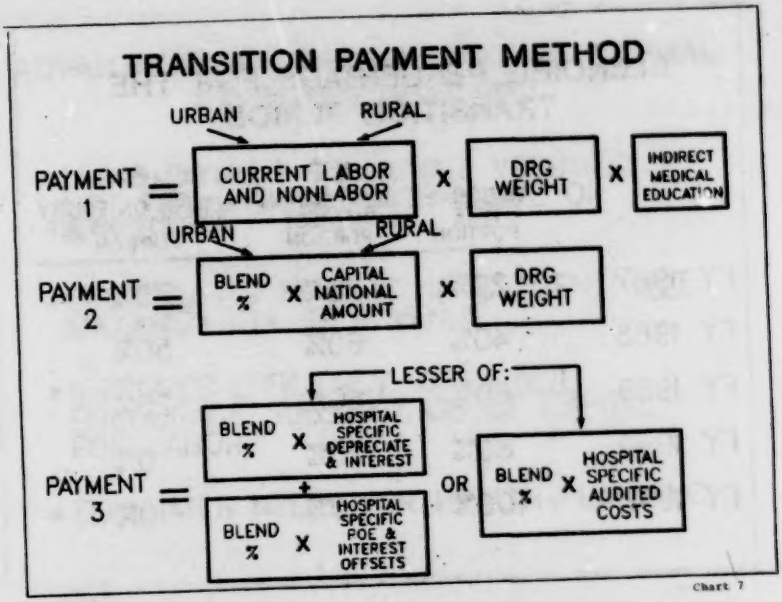


Chart 7

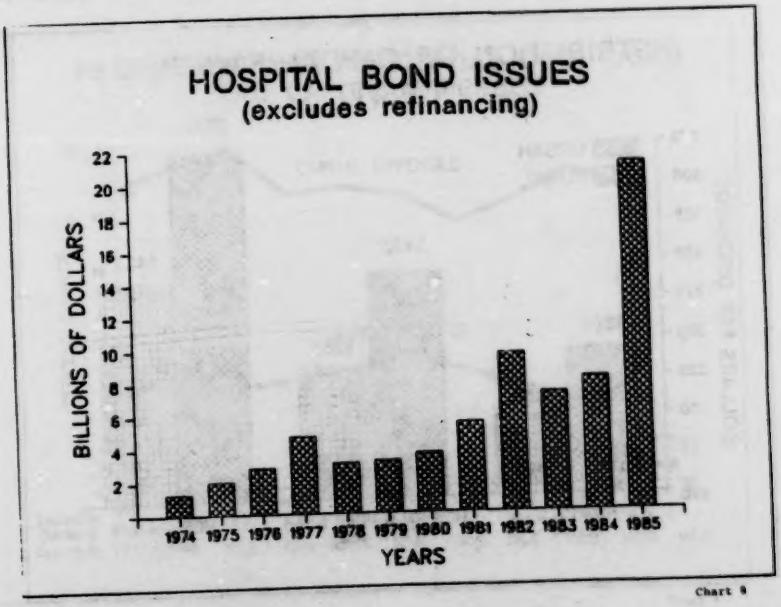


Chart 8

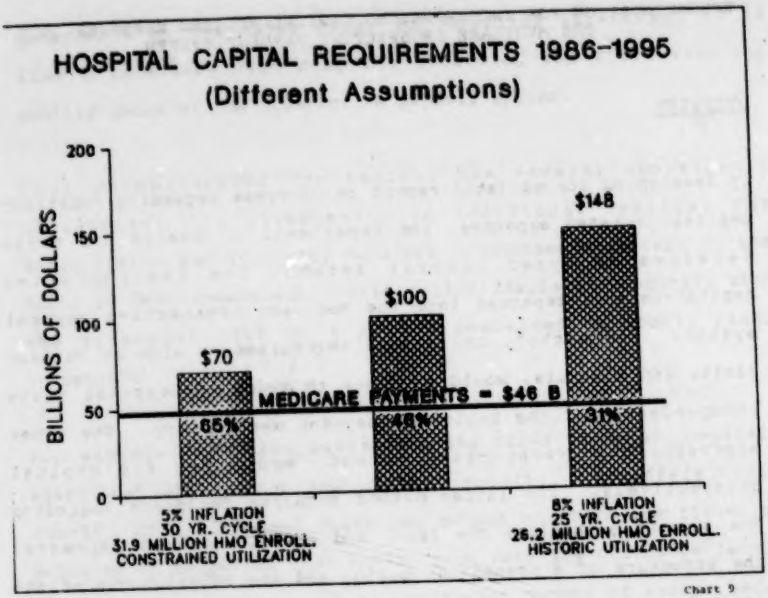

HOSPITAL CAPITAL REQUIREMENTS 1986–1995
(Different Assumptions)
BILLIONS OF DOLLARS
200
150
100
50
0
$70
$100
$148
MEDICARE PAYMENTS = $46 B
65%
48%
31%
5% INFLATION
30 YR. CYCLE
31.9 MILLION HMO ENROLL.
CONSTRAINED UTILIZATION
8% INFLATION
25 YR. CYCLE
26.2 MILLION HMO ENROLL.
HISTORIC UTILIZATION

Chart 9

RECOMMENDATION FOR INCORPORATING CAPITAL RELATED EXPENSES INTO THE MEDICARE PROSPECTIVE PAYMENT SYSTEM

OVERVIEW

In developing our mandated report to Congress regarding inpatient capital- related expenses, the Department of Health and Human Services analyzed several methods for incorporating capital-related expenses into the Medicare prospective payment system. One method, cost-based reimbursement with or without limits and controls, would continue to reimburse capital costs independently of the basic DRG payment methodology. The other approach, the average-rate method, would pay for capital prospectively. The latter method requires decisions regarding the payment mechanism, the level and distribution of payments, the structure of a transition period and the relationship of the capital payment to the current prospective payment system.

Although the Congress requested only a study of methods for incorporating payments for capital into the prospective payment system, we chose to examine a broad range of options for making capital payments to hospitals. From our analysis, we have concluded that many of the possible methods for paying hospitals for capital related expenses are not consistent with the goals of administrative simplicity, flexibility for hospital management, predictability of payment, and incentives for efficiency.

Based on analyses conducted pursuant to our study contract with ICF, Inc., using their Hospital Investment Simulation Model, we believe that amounts for capital can be averaged into the DRG payments. We have concluded that such a change in Medicare reimbursement policy for hospital capital would be a major step toward a more rational and less interventionist role for

government as the major payer for hospital services. It is also a necessary next step for attaining the efficiency and quality goals of the prospective payment system.

Cost reimbursement for capital has several undesirable attributes. In reimbursing an individual hospital for depreciation and interest, Medicare reimburses hospitals on the basis of past investment. This policy insulates hospitals from the financial risk of a poorly conceived or poorly timed investment.

For example, Medicare subsidizes the fixed costs of hospitals associated with excess and unused capacity. In effect, this subsidy of total fixed costs has helped maintain the financial solvency of hospitals that suffer from very low occupancy levels in geographical areas with a significant number of excess beds. In general, if a hospital's fixed costs or overall debt service expenses are being covered, it can financially survive prolonged periods of low occupancy, provided its staffing and other operating costs are aligned with its actual occupancy level, and not its total bed capacity. In competitive markets and areas with good access to hospital care, Medicare has been inappropriately subsidizing underutilized hospitals that simply are not able to attain a reasonable market share. This subsidy has been estimated by Medicare studies to range from $8,400 to $27,900 per bed per year, depending on the staffing level associated with the bed.

Cost based reimbursement also produces enormous inequities in the ability of different classes of hospitals to make capital investments. Since payments are based on each hospital's financing costs for capital, on the value of its current assets

and on its total bed capacity, there are large disparities in Medicare payments for capital to different classes of hospitals for reasons unrelated to the care of Medicare patients. For example, Medicare makes high capital payments, on average, to many hospitals primarily because those hospitals in the past have been credit-worthy, have had good access to capital markets, and have used that access to invest heavily in capital inputs. On the other hand, Medicare makes low capital payments to hospitals such as large public hospitals and to other hospitals which are less credit-worthy and less able to obtain financing for capital investment. This inability to access capital markets is often associated with the need to direct financial resources to the subsidization of other operating expenses, such as charity and bad debt, at the expense of their capital plant, rural location and nonparticipation in a multiple hospital system.

In sum, the current cost pass-through for capital displays the same problems and liabilities as did the pre-prospective payment system for operating costs. It provides the wrong kind of incentives for hospital managers; it requires detailed cost reporting; and it makes payments that are difficult to predict for Federal budget purposes.

Medicare's cost reimbursement system subsidizes hospitals which are not economically viable and which are not needed for patient care. In this time of scarce resources, Medicare cannot continue a policy that subsidizes inefficient economic units that are not needed to maintain access to high quality care. Further, the Federal government cannot sustain a policy that rewards hospitals based on their ability to access capital markets, instead of rewarding them for the provision of care to Medicare beneficiaries.

Our proposed payment system would break the link which relates Medicare capital payments to the value of a hospital's current assets rather than to its Medicare volume and case-mix. Currently, assuming the identical Medicare utilization, a high capital asset base generates capital-related revenues, while a low capital asset base generates low capital-related revenues. With our policy, payment for capital would be linked directly to real Medicare volume (i.e., discharges) rather than total-- and frequently unused-- capacity.

1. Recommendation

The Department's recommendation is based on our conclusion that the hospital industry is currently experiencing a significant and costly excess capacity. There are currently 4.5 beds per 1,000 population nation wide and many areas are experiencing significantly higher rates. Current demand for beds is only 2.5-2.7 per 1,000 population and is expected to decline below this rate with the continued growth in alternative site providers, such as ambulatory surgery centers.

Beds in excess of the optimal rates including the associated staff and equipment greatly decrease the efficiency of the care provided. In fact, excess capacity may tempt hospitals to provide more care than is medically necessary thereby increasing the risk of an adverse medical outcome.

The Medicare cost reimbursement system for capital is a major contributor to the 40% idle capacity in the hospital industry. This level of unsed capacity would be unsustainable in any industry other than hospital industry where a hospital is guaranteed cost reimbursement for its capital irrespective of the demand for its services. Industry wide current capacity

utilization is in excess of 80%, according to the Federal Reserve Board. The automobile industry is at an 87.7% capacity, and even public utilities are at a 82.7% utilization rate. Despite these rates, most economists do not believe that utilization is sufficient to warrant spending on new plant and equipment.

Considering that community hospitals alone had annual revenues of $133.5 billion in 1984 amounting to 3.5% of GNP the economic cost associated with its unused capacity is significant. Yet the hospital industry continues to expand capital investments. Even allowing for geographical variation in demand and supply for hospital services, continued hospital investment at historic rates of at a time of declining utilization would not seem to be prudent.

In order to be a prudent purchaser of hospital services, Medicare should correct for the inefficiencies created by its current reimbursement policy, but it must do so without reducing either the quality of care provided or access to that care for Medicare beneficiaries.

As requested, we recommend a proposal that would accomplish the following:

(i) Reward hospitals for treating Medicare patients and not for accessing the capital markets by establishing an all-inclusive prospective payment amount that would pay hospitals an average amount per Medicare discharge. This payment amount would not distinguish between payments for capital and operating expenses.

(ii) Reduce Medicare payments to hospitals for capital by establishing a national payment amount that does not

include payments for return on equity for investor owned hospitals and payments to hospitals for interest on funded depreciation.

(iii) Provide for an adequate transition period from current cost-based reimbursement to the prospective payment system in order to allow hospitals the necessary time to adjust to the new payment system while assuring that hospitals do not over-invest during the transition.

(iv) Continue cost reimbursement for capital for hospitals that are subject to special rules under the prospective payment system for operating costs.

2. Outline of the Recommended Policy

Mechanism: Build into the non-labor component of the standardized payment amounts for rural and urban hospitals an amount for capital. This amount combined with the current non-labor amount will constitute the standardized payment amount for Medicare PPS hospitals. After inclusion in the standardized amount, capital payments will be indistinguishable from other non-labor payments. Table I depicts how the payment mechanism would operate when fully implemented.

Payment Levels: During the transition, separate standardized capital payment amounts will be established for rural and urban hospitals, as designated by current PPS regulation. These standardized payment amounts for fiscal year 1987, the first transition year, will be established from 1983 audited cost report amounts updated to 1986 by the Medicare capital market basket for fiscal years 1984, 1985, and 1986. Aggregate return

on equity and interest offset amounts will be excluded from these computed standardized amounts.

Transition: Separate payment levels for depreciation and interest, and for Return on Equity (ROE) and Interest Offsets (IO) will be established for each hospital based on audited 1986 cost reports. During the transition these two unique HSP amounts will be updated from year to year after 1986 using the actual hospital capital market basket. In each year of the transition a hospital will be paid the lesser of the sum of their two payment amounts, or their actual audited capital costs, after the appropriate blend proportions have been applied.

The transition period is designed to fully implement an all inclusive prospective rate for Medicare by 1991. The transition involves separate schedules for phasing out hospital specific payments for depreciation and interest, and for return on equity and interest offsets on funded depreciation and charitable contribution payments. The blending proportions for the two schedules are depicted below:

Blending Percentage for the Transition Period

	National Rate Portion	HSP Depreciation Interest Portion	HSP Return on Equity Interest Offset Portion
FY 1987	20%	80%	75%
FY 1988	40%	60%	50%
FY 1989	60%	40%	25%
FY 1990	80%	20%	0%
FY 1991	100%	0%	0%

For example, hospitals in 1987 will receive 75% of their ROE-IO plus 80% of their depreciation and interest plus 20% of the national rate. In 1991, they will receive a single payment for each discharge equal to the sum of the national rates for capital

and for operating costs. Table 2 depicts graphically how the transition period would work.

Hospitals will be paid their actual costs for Depreciation, Interest, ROE, and Interest Offsets in 1986 under current reasonable capital cost procedures. The transition to the national rate will be implemented beginning October 1986 according to each hospital's accounting year.

Update Factor: A capital component will be incorporated into the hospital market basket. The PPS standardized amounts will be updated during the transition and subsequent years by the DRG update factor as determined by the Secretary of HHS. The Secretary will take into consideration the capital needs of the hospital industry when establishing this factor. The HSP amounts during the transition will be updated each year by the capital component of the hospital market basket as discussed below.
Capital related items will be incorporated into the Medicare hospital market basket. Disaggregation of the standardized amounts will be accomplished as it is under current policy. The relative labor and nonlabor proportions found in the market basket will be applied to the standardized amounts to produce the separate labor and nonlabor amounts used to make PPS payments to hospitals.

3. Implementation of the Recommended Capital Policy: We agree with the Congressional Research Service that current law allows us to include capital in the prospective payment rates administratively beginning October 1, 1986. Under section 1886(d)(1)(A) of the Social Security Act, the fixed prospective payment rate is the only Medicare payment authorized for "operating costs of inpatient hospital services." These costs are in turn defined in section 1886(a)(4) as excluding

capital-related costs only for cost reporting periods beginning prior to October 1, 1986. Thus, capital reimbursed after that time would be through its inclusion in the prospective payment systems. This interpretation is confirmed by the Conference Report on the bill establishing the prospective payment system (House Conference Report No. 96-47), which noted that the conference agreement followed the Senate version of payment for capital-related costs and summarized the Senate version at page 189 as follows:

> "Under the Senate amendment, capital expenses, as defined by the Secretary, would be specifically excluded from the prospective payment system until October 1986, during which time they would continue to be reimbursed on a reasonable cost basis. After October 1, 1986, such expenses would no longer be excluded."

That the conferees expected capital to be included in the prospective payment rates as of October 1, 1986, is further clarified on pages 189-90 the where conferees stated:

> "The managers expect that additional legislation will be enacted by Congress to deal with capital-related issues under the prospective payment system before October 1, 1986. However, if the Secretary has implemented a system of prospective payment for capital without legislative action and the mandatory section 1122 capital planning approval provision has gone into effect, the conferees intend that the Secretary will adjust the prospective payment for capital to reflect a disapproval project under section 1122."

Thus, the conferees foresaw the possibility that if Congress did not act before October 1, 1986 to legislate capital-related

costs under the prospective payment system, the Secretary would do so by regulation.

In proposing this approach we have attempted to be realistic about the current financial conditions of hospitals as well as the need to restrain the growth of Medicare expenditures. It is our hope that we have devised a policy that is both realistic and fair to all concerned. We welcome the attention of Congress to this most important issue affecting the future of our medical care system.

TABLE 1

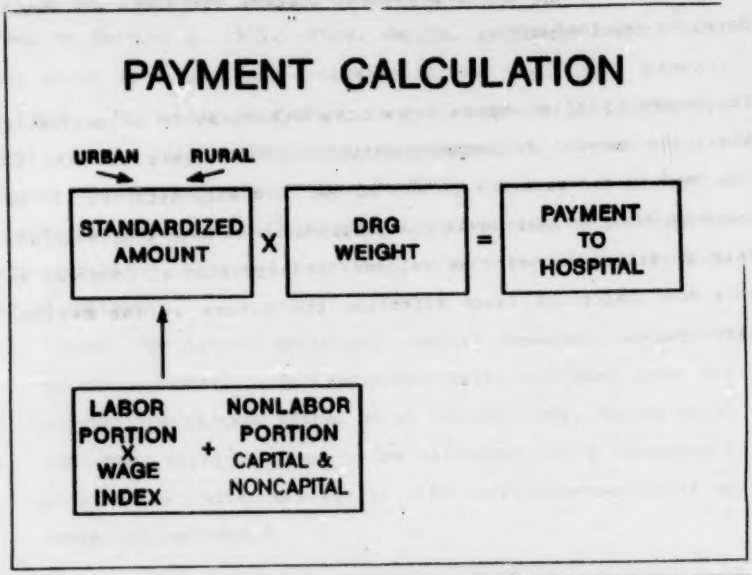
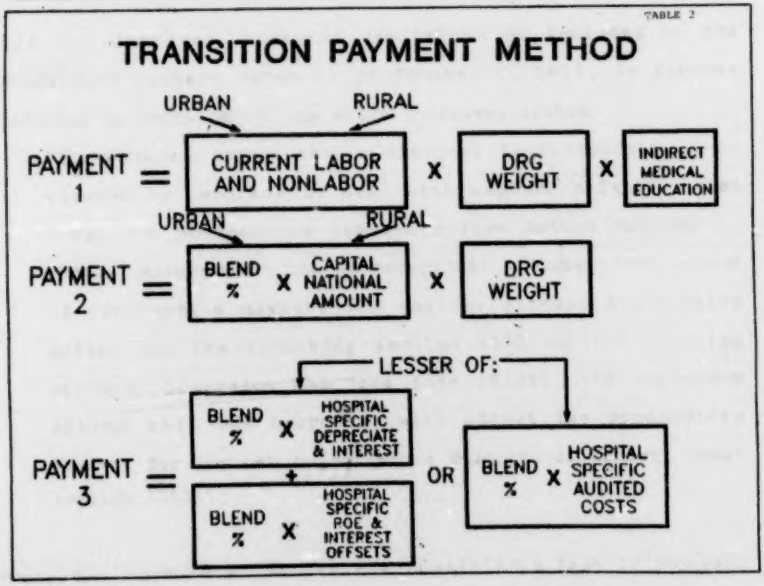


TABLE 2



Chairman STARK. Just for my information, do you know what the mean standardized amount is right now? Do you have any idea? I would just like to know.

Mr. TEACH. Close to 3,000.

Chairman STARK. This would be the increase on the 3,000, OK.

Mr. HELMS. All right. These are the hospitals. So we have a 4-year transition.

In our 4-year transition, these are the numbers of hospitals in urban and rural areas—these are the ones who will gain and these would be the ones that stand to lose.

The point is, the longer you make this transition, the easier it will be on all these hospitals, the worse it will be on these. We tried to pick a transition that we think would be beneficial to the majority of these hospitals and that is why we picked the 4 years. It is also why we picked the 1986 amount for the hospital-specific amount.

Mr. PICKLE. Are you picking the most recent 4 years?

Mr. HELMS. Well, the 4-year transition would start in 1987. That is the first year. So it goes from 1987, 1988, 1989, 1990. They are the 4 years of the transition. This is our estimate of the amounts that would be paid in 1987.

Chairman STARK. Do you have a table that would compare your last chart with what will be happening in 1991 when the system is fully implemented?

Mr. HELMS. Not with me.

Chairman STARK. Can you supply that to us? I suspect that would make a major difference, wouldn't it?

Mr. HELMS. Yes, I think we can try to do that.

[The information follows:]

Comparison of estimated 1987 and 1991 savings

Estimated current services capital payment per case 1987	$471.77
Estimated average capital payment per case with proposal	398.27
Estimated current services capital payment per case 1991	726.20
Estimated capital payment per case with proposal	352.95

Mr. HELMS. Let me go over some of the mechanics of the payment now. It will explain this last point here.

During the transition period, of course, the hospital is going to be getting three different payments. Mr. Pickle, I hope this answers your question.

The first is this operating payment which they are getting now. It is based on the current labor and nonlabor component of the urban and rural standardized amounts which are adjusted by the DRG weight. And for teaching hospitals it is multiplied by the indirect medical education adjustment.

The second payment is the national portion of the capital amount, which in the first year would be 20 percent, times the capital national amount, again for urban and rural. That is adjusted by the DRG weights and that goes to the hospital.

The third is a little more complicated, but what we are proposing is that the payment be the lower of the hospital-specific part of the payment which goes to each hospital based on its historic cost reports, or its 1986 hospital-specific costs updated. The approximate blend percent would apply here too.

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The blend percent, of course, in the first year is 20 percent. We would pay the lesser of these two amounts. Let me explain why. This would be the hospital-specific depreciation and interest as updated by their capital market basket. In other words, what they show as interest and depreciation on the 1986 cost report, updated by the capital market basket to 1987 plus the blend percent, which would be 75 percent, of their due for return on equity and interest offsets, also updated by that index factor.

We would calculate these amounts and pay whichever is less.

The reason for doing this is that there are a number of hospitals whose capital costs go down naturally and we don't want to overpay them in that case. So we are trying to fix it on a 1986 base updated with an index and pay the lesser of these two amounts.

Mr. GRADISON. If I may, you don't adjust for those whose hospital-specific capital costs are going up, just those which are going down; is that correct?

Mr. HELMS. We only adjust by the market basket for capital.

Mr. GRADISON. That is not a hospital-specific calculation; that is a macro.

Mr. HELMS. That is correct. But they start with the 1986 hospital figure for each hospital, you are right.

Now, a couple of other points here. For new hospitals which do not have a 1986 base, they would get 100 percent of the national rate any time they came into existence during the transition. That is the same procedure that HCFA has used with the operating cost for new hospitals.

Also, we would continue to exempt any hospitals which are treated as special cases. They would continue on a cost-based system.

A couple of other points about the effects of this. When we considered how to or where to set this 1986 amount for the hospital-specific figure, we will look at the amount of hospital bonds being issued. Historically, these have been running at $6 billion in here, at that level.

As you can see, in 1985 it went up to $21.1 billion. Of course, the reasons for that I think have mostly to do with fears about the changing of the tax laws and so on.

But here you have a situation where there has been a lot of refinancing, at the same time that the number of actual issuances went down, which means there are a lot of bond issues that account for a large amount of this $21 billion. But this amount excludes refinancing so we are just talking about bond financing of new equipment and construction.

This amount is going to appear on the cost reports in later years. We think an industry which has all this excess capacity and, as I said before, is continuing to invest, may be doing this because of the rules of PPS and we don't think it is appropriate. That is one reason we tried to fix 1986 for the hospital-specific amount.

One last chart, and I'll give somebody else a chance to talk. I want to go back to studies done by a number of outside experts a few years ago on what the capital requirements would be of the hospital industry in the decade from 1986 to 1995. There is a big literature source on this and a lot of different outside financial experts have tried to estimate this.

One study was done that compared all these, and what they found out was these studies varied a great deal by what you assumed happens, primarily to inflation rates and utilization factors. As it turned out, they estimated that if there were low inflation, a 30-year reinvestment cycle, and very high HMO enrollment and constrained utilization, that the capital requirements for the decade would be only around $70 billion. But if you assumed the higher rates of inflation and historical utilization, they would be up around $148 billion.

Just for a percentage purpose, we think this lower figure is closer to the existing situation with inflation and utilization both down. But even if you expect inflation to heat up and maybe the estimates are a little wrong, and you say it is going to be higher than $100 billion, we estimate under our proposal that during this decade Medicare is still going to pay out $46 billion to hospitals.

This is going, we say, to maintain the approximate historic levels of the proportion of Medicare payments which Medicare has been making in the past.

Chairman STARK. It came out by accident that way, maybe?

Mr. HELMS. No. The actual Medicare proportion is probably a little lower than that now.

Mr. PICKLE. Before you take your gear off, Dr. Helms, put up the chart there about the bond matter. In 1985, you issued more bonds, over two times more.

Mr. HELMS. These are bonds issued by bonding people who write hospital bonds, financial bonds.

Mr. PICKLE. I understand that.

Well, in 1985 over twice as many bonds were issued than in 1984, and 10 times what was issued back in 1970, or whenever the first chart—20 times more.

You said that may represent the uneasiness in the bond market. Obviously, that has to be a factor.

Do the hospitals need all those bonds issued? Is there a need for it? Is there a reason for it, or are they just issuing bonds because they think it would be a good time to issue them?

Mr. HELMS. Well, that is a question I would like you to put to some of the rest of the witnesses.

Mr. PICKLE. Well, I am putting it to you first.

Mr. HELMS. I know, but I am with the Government, and I would only say there are a lot of financial reasons they wanted to do that and I think one of the reasons is to take advantage of this interim period we have.

We have a situation where people are being paid on prospective payment on the basis of fixed amounts for operating costs and yet they are still getting cost reimbursement for capital.

So that creates incentives for more capital expenditures, particularly if that investment reduces your cost. It is a very good investment because it lowers the operating cost. Yet, you get dollar-for-dollar reimbursement on the cost-based reimbursement side.

So I think mostly it had to do with the incentives created by—well, the expectations that the favorable treatment for tax-exempt bonds was going to change.

Mr. PICKLE. That might be a reason.

Mr. HELMS. In the sense there is a doubling of the need for new capital funds here, you know, again I would like to ask the hospital industry that.

Mr. PICKLE. Well, we will.

Mr. HELMS. When you have overcapacity.

Mr. PICKLE. What you see in that chart right now is typical of all kinds of expenditures in the bond market. All tax-exempt bonds were more than doubled from 1984 to 1985. It is even more than that for the hospitals.

You have to ask yourself, why is that? Now, it might be there is incentive because of return on equity and so on; you may want to invest more in it, I don't know. It ought to be a matter that concerns the administration.

Do you have any recommendations as to the amount that we should—if we made a change in the tax bill in the House side, be giving an extra amount on the 501(c)(3)? Will that be sufficient to help the hospitals? Are you familiar with that provision?

Mr. HELMS. No, sir.

Mr. PICKLE. Well——

Mr. HELMS. Let me just say what we propose is going to be adequate for hospitals. We are still going to be paying out quite a few billion dollars over the next few years. That is going to help the majority of the hospitals, but it is going to hurt some of those which are probably the ones that are responsible for a lot of this $21 billion financing.

Mr. PICKLE. Let me ask you, does it concern you that the amount of the bonds in 1985 were almost triple what they were in the last year or two as a representative of the administration? Do you think that is normal or what?

Mr. HELMS. From a reimbursement point of view, it concerns me, yes. I see in that the expectation that a lot of this is going to show up on our cost reports if we keep cost-based reimbursement for several more years. That is going to show up on the cost reports and the trust fund will be obligated to pay it out at much higher rates than we are currently paying out for capital.

Mr. PICKLE. If I can ask one more question, Mr. Chairman, and I will excuse myself.

Chairman STARK. Go ahead.

Mr. PICKLE. In making estimates of the payment, you take a 4-year basis, 1987 to 1991. Is that a short period, is that too short? Should there be 8 or 10 years there instead?

Why do you take a short period, just 4 years, which represents all current expenditures and nothing for commitments made in the past?

Mr. HELMS. As you know, that has been debated for a long time. Sure, you will hear lots of people testify that they think it should be longer. We picked the 4 years because we think that is adequate.

We also think that it is a system that helps well over half the hospitals who will be better off the faster this is implemented. But it is going to be tougher on those who are above the average. They are not many, but most of the ones that have done most of the recent financing.

There is no magic answer to what that transition should be. We think 4 years is a reasonable one. It gives everybody a chance to adjust to it.

But I can point out that if you make it longer, those people who otherwise would have gained from a shorter transition will not be helped as much right away.

As you consider this—I did want to say this. I would be glad to answer more questions, but I did want to say, as you consider this, we will be glad to continue with the good cooperation we have had with your staff on analyzing different options that you may come up with and we will do our best to answer these other technical questions.

Mr. PICKLE. In the bond markets, does that represent both public and private hospitals' bond issues?

Mr. HELMS. These are tax-exempt bonds so that——

Mr. PICKLE. I understand that.

My question is, does it include both public and private issues, 501(c)(3)s?

Mr. TEACH. Yes.

Mr. HELMS. I think so, yes.

Mr. PICKLE. Thank you.

Chairman STARK. Could we go back to the last paragraph on hospital capital requirements, the different assumptions?

In the present system you are saying that, Medicare pays 46 percent of the hospital capital requirements? The percentage just happens to equal $46 billion and 46 percent?

Mr. HELMS. What I was trying to say here is it if turns out that the hospital requirements are $100 billion, we expect we would be paying about 46 percent. We have been paying around 40 in the past.

Chairman STARK. OK. In the aggregate is it 40 percent?

Mr. HELMS. In the aggregate, yes.

Chairman STARK. Let me get to that.

For simplification, if you have a hospital with 100 beds, how do you decide which, or what percentage of their capital cost Medicare pays now under the present reimbursement system?

Mr. HELMS. It is a system that has been——

Chairman STARK. How do you get to the percentage? Would it be 100 percent of capital?

Mr. HELMS. No, it is paid on the basis of their Medicare proportion of their occupied—wait a minute. Let me say it this way.

What they put on their cost reports, let's simplify it to interest and depreciation. If I get this wrong, correct me.

Then they say, what is the proportion which Medicare makes up of that total amount?

Chairman STARK. How do you get that? That is what I am asking.

Mr. HELMS. That is done on the basis of patient days.

Chairman STARK. Income?

Mr. HELMS. Patient days, total days.

Chairman STARK. So let's just assume you have got 350 days and you have 100 beds, that hospital then has 35,000 patient days, is that correct?

Mr. TEACH. Yes.

Chairman STARK. OK. You go back historically over a couple years then, or do you do it each year?

Mr. TEACH. Each year you would be reconciled.

Chairman STARK. Let's assume for the moment, then, that the hospital has income—takes in 175,000 patient days and they are all Medicare patients. You pay 100 percent of their capital costs?

Mr. TEACH. Yes, that is correct.

Chairman STARK. Even though the hospital in that case itself is sufficiently running 50-percent occupancy.

Mr. TEACH. That is absolutely correct. That is what I was afraid of.

Chairman STARK. Do you have any idea what the aggregate is? How much have we been oversubsidizing? How much have we been subsidizing vacant beds, in a sense, if we had been more accurate in our planning? Do you have any numbers there?

Mr. HELMS. We computed that at one time.

Mr. TEACH. The Health Care Financing Administration has done some studies on what the cost of an unoccupied bed amounts to and the estimates range from about $8,400 to $27,000 a year based on what the staffing associated with that bed is.

Chairman STARK. I guess I am——

Mr. HELMS. That is a different amount than what you——

Chairman STARK [continuing]. I guess what I am getting at is if a hospital has a high percentage of Medicare patients and also a low occupancy, then we are really subsidizing a tremendously inefficient hospital plan through Medicare. Do you correct that in this procedure?

Mr. HELMS. It certainly does.

Chairman STARK. On the other hand, we may have encouraged that overcapacity by authorizing that hospital in the first place.

There was some Federal procedure that they had to get a permit in the first place, right?

Mr. HELMS. HCFA rules say we will pay on the basis of their percent occupancy. We end up subsidizing.

I think at one time—I don't have it with me—but we had computed that amount but we will try to do that for you again.

[The information follows:]

Medicare subsidy of unoccupied hospital beds

Statistics from Mark Pauly:

Cost per unoccupied bed (expected to be empty) per year (13 percent of the cost of a filled bed), $8,400.

Cost per unexpected unoccupied bed per year (43 percent of the cost of a filled bed), $27,785.

Number of unoccupied beds (June AHA panel survey), 337,487,340.

Number expected to be empty—5 percent of all beds, 48,629,300.

Number not expected to be empty, 288,858,040.

Annual Medicare cost of unoccupied beds (assuming 5 percent of all beds expected to be empty), $3,373 million.

Mr. HELMS. That has been one of the major criticisms of cost-based reimbursement and this system we are proposing—an averaging system with the capital payments included in the DRG's—you get out of that because then we are paying only for the Medicare admissions.

Chairman STARK. Did you consider in your deliberations hold harmless or floors and caps to prevent windfalls as an addition to this system or as an alternative?

Mr. HELMS. We have considered some of that in a sense going to the 1986 base.

Chairman STARK. I mean on a specific basis.

Mr. HELMS. On the hospital-specific amount?

Chairman STARK. You are saying that no hospital for 5 years will collect less in capital payments than what it has been getting, and no hospital will get more than the cost of inflation plus change or some limit to what they can get on the windfall basis or a floor under which they couldn't be harmed.

Mr. HELMS. We considered that but we think we took care of it with this system.

Chairman STARK. You did consider a program like that?

Mr. HELMS. Well, not very much in detail, but, yes.

Chairman STARK. Do you have any feeling about that? I have a hunch we may hear testimony later that that kind of a system might make people happier.

Mr. HELMS. I don't think it will preclude it because I don't see that you are in danger of somebody getting enormous payments.

Chairman STARK. They won't testify to that today, I am sure. You can rest assured.

Mr. HELMS. Sure.

Chairman STARK. But how about the ones that are going broke today? You didn't consider——

Mr. HELMS. Some floor, no.

Chairman STARK. OK. Or any real reasons why that would be a horrendous problem.

Mr. HELMS. We have heard their arguments but we don't think it is a major problem.

Chairman STARK. If you don't think it is a major problem, what is the problem of putting it in? That would cut down on the argument.

Mr. HELMS. My point is we don't think it would be a problem. I think the Congress gave people ample warning in 1983 that this system was going to change. If we have a 4-year transition starting in 1987, I think that is enough time.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I would like to pick up on that point—on whether it is enough time.

Dr. Helms, earlier you said 4 years gives everyone a chance to adjust to it. If you were running an institution which had committed to a large capital program before 1983, but actually undertook it starting in 1983—and I know of such institutions as I am sure you do—then we implemented or you implemented what you are talking about, how would you go about adjusting to it?

You are saying this gives them a chance to adjust. How do they adjust to it? Default on the bonds? Close up shop? What do they do?

Your own figures and the industry's figures show that as a percentage of operating cost, capital costs vary from about zero in old institutions that have not spent anything for a long time up to numbers approaching 25 percent. Twenty percent is certainly

within the realm of what we are seeing in some of them. That is off the edge of the curve, the bell curve, but it is on the curve.

If you were one of those 25-percent institutions and you got 4 years, how would you adjust to it?

The bonds are outstanding. Let's assume that. What do you do next?

Mr. HELMS. What you are talking about are the hospitals that you said are off the extreme end of the distribution. I think they have had several years of warning.

The thing they can do is try to go in there and do something about their costs to try to get operating costs down further because under this system, they are going to get the dollars and if they can get their costs down, they can keep the difference. It is still consistent with that.

Other than that, no, it is going to be hard on the ones that are particularly far out on that distribution curve.

Mr. GRADISON. Which tend to be the ones that have spent the most money in recent years to modernize and reequip.

Mr. HELMS. That is right, because under a normal investment cycle, if they spent that for the years before, they would have gone down in their investments already.

Mr. GRADISON. Have you done studies of specific institutions at various parts of their rebuilding cycles just to test this out? If you have, could you share the numbers with us for the record so we can look at them, too?

Mr. HELMS. We have done some studies on what we call high capital cost hospitals at 14 percent or over in terms of ratios. We would be glad to share that with you.

I think under this proposal, we would probably better rerun that, though. I think that is not particularly up to date.

Mr. GRADISON. Could you do that?

My hunch is that we will hear about that and I would like to see your numbers.

Mr. Helms, in developing the prospective payment system for operating costs, we explicitly acknowledged there are going to be some hospitals off the extreme end of the distribution. We developed a new term, outliers, to apply to them.

I wonder conceptually why, during a reasonable transition period, that same notion of outliers can't be applied to capital costs the same way it is being applied it to operating costs.

I am not objecting to where you want to end up; it is just how you get there. To be honest with you, my hunch is if you have a system that gets there by undermining the financial strength o modernized institutions all over the country, all you do is provoke us to do what we might do anyway, which is to pass a law prohibiting the regulations, which doesn't move the issue ahead at all.

How about these outliers?

Mr. HELMS. I think you have several choices here. Everything you do, of course, to take care of these outliers you are going t slow the gain of the much larger number of hospitals, as I sai before.

You could have an outlier policy. We didn't choose to propos one, but if the Congress would like to do that, that is of course you prerogative.

On the other hand, you can also help the outliers by making the transition longer and making it uneven and keeping the total amount of money higher. All of those will delay the time when their hospital-specific payments will actually go down.

But every time you do that, as I say, you trade off, help those people at that end at the expense of all the others.

Mr. GRADISON. It is great to set up winners and losers hoping the winners will come in and say, do it the way you suggested. I doubt it is going to work out that way. We usually hear from the losers rather than the winners in games like this.

But you could be extremely helpful to us if we decide to explore this approach of outliers because there might be some point, and I don't know what it is, just picking a number, but there may be a point like 10 percent, or something in that order, where you could legitimately say, given a certain number of years, they can work it out themselves by tightening up operating expenses. One could make that argument.

I have no idea how large this group is, but there may be a group above that breakpoint with a different approach, where it may be different. Any numbers you can give us on this would be extremely helpful.

Mr. HELMS. As I said before, any proposals which you would like to put forward we will certainly try to do our best to analyze them and tell you how many hospitals we think will be in that class and the pros and cons of setting those different limits if you choose to do that.

Mr. GRADISON. Do you think that this plan if adopted will stimulate further mergers in the hospital industry?

Mr. HELMS. I think you are going to get further mergers in the hospital industry whether you go with this or stay with cost reimbursement. I can't see this having much of an effect in itself.

I just read several articles in hospital magazines about the future market in the hospital industry. And these are outside experts, not Government people, saying these things, but I think there is a much bigger force other than Medicare—as I say, we will still pay out $46 billion over the next decade under this plan. The much bigger force is what is happening in the overall market in hospitals. It is becoming very competitive.

The occupancy rates are down and more and more physicians are competing with the hospitals for outpatient business. HMO's are growing. Other kinds of at-risk systems are growing.

So I think that is the phenomenon that will probably cause either mergers or failures of hospitals.

Mr. GRADISON. Thank you.

Mr. HELMS. Of course, Medicare will probably get blamed.

Mr. GRADISON. Thank you.

Thank you, Mr. Chairman.

Thank you very much, Dr. Helms.

Chairman STARK. Just a couple more questions, Doctor.

In 1985, did we spend $3 billion in capital costs? Is that what it costs Medicare to run?

Mr. HELMS. That was in 1983, I think. It was $3 billion.

Chairman STARK. Do you know the numbers for the last year?

Mr. TEACH. Probably $3.8 billion in 1985.

Chairman STARK. Now, what under the present system, without a change, did you project out to 1985, and 1986? Can you run down that column with me or aggregate it?

If we continue the present system, what are the baseline numbers? I don't have it here. I just want some relative numbers.

Mr. HELMS. We think we have it, if you will give us a second.

[The information follows:]

Baseline medicare capital expenditures

	Millions
1986	$4,457
1987	5,140
1988	5,919
1989	6,818
1990	7,852
1991	9,032

Chairman STARK. Ernst and Winney provided me with some numbers. Let's try theirs.

Mr. TEACH. Probably a close relationship actually.

Chairman STARK. I presume the forecast of impatient hospital captial costs is under the present system: $3.5 in 1984, $3.9 in 1985, $.4.5 in 1986, $5.1 in 1987, $5.9 in 1988, $6.8 for 1989.

Mr. HELMS. I think that is what the actuaries termed the numbers in the budget.

Chairman STARK. Under your program, the transition, starts in 1987?

Mr. HELMS. Right.

Chairman STARK. So we have to compare 1987 here and they are talking about $5.1.

What would you guys spend under your proposal in 1987-88? Would you run that out for us, please?

Mr. HELMS. It is in the budget. We have everything but that.

Here it is. In 1987, we are showing $5.4 billion current policy, and $4.68 under our proposal.

Chairman STARK. $4.68 billion. Can you run down 1988 for me?

Mr. HELMS. 1988 is $4.483; 1989 is $4.538; 1990 is $4.667, and 1991 is $4.933.

Chairman STARK. You show a bit of a saving here, then.

Mr. HELMS. Yes, but——

Chairman STARK. That is all right. Do you have the figures available on a 7-year transition? What are the numbers on that?

Mr. HELMS. I don't have those. We can try to get them for you.

[The information follows:]

Capital savings assuming an uneven 7-year transition

	Millions
1987	$66
1988	210
1989	511
1990	1,124
1991	2,060

Chairman STARK. Do you have them with you?

Mr. HELMS. I think they are in the little booklet, you said, but I don't know. We don't have those with us.

I think we are trying to do some estimates even on Mr. Durenberger's bill so we will try to get that for you.

Chairman STARK. Your original proposal, as I understand, was for a 7-year transition, is that correct?

Mr. HELMS. Excuse me.

Chairman STARK. HHS's original proposal was a 7-year transition, is that correct?

Mr. HELMS. That is correct.

Chairman STARK. OMB said to cut it back to 4 years, is that correct?

Mr. HELMS. Well, let me put it this way: The original proposal was never really agreed upon. It is called in the booklet you mentioned the HHS proposal but it was made, I think, up through the domestic policy council that was before passage of Gramm-Rudman.

Chairman STARK. But it was still originally 7 years?

Mr. HELMS. Yes.

Chairman STARK. I can't do the numbers right here very quickly, but you are at 20 as opposed to 35. So you are about 50 percent lower at 4 years than present law.

Mr. HELMS. Let's see, 1990, the current law estimate is $7.852 billion. That compares with our proposal of $4.667 billion.

Chairman STARK. I gather this chart takes into account other things but it runs $5.25 and $8.4. Are your numbers flat at $4.2 under the 4 years?

Do you recall under the 7-year transition, was that closer to following present law or was it still flat in reductions? I just want to get some idea.

Mr. HELMS. As I remember, it would be much closer to the projection of current law because one of the features of that proposal was that on the hospital-specific side, we didn't freeze it in 1986; we paid what was on the cost report for each hospital in that time.

Chairman STARK. So without pinning you down, I would like these numbers later. If we were going to somewhere, say, it is in the area of between 6 and 10 years, adjust the transition, we could pay out to hospitals—I am not suggesting hospital-specific, but in the aggregate we would be spending about as much in capital repayment through 1990 or 1991 as present law had anticipated.

Mr. HELMS. Yes, I could do that by that. But remember, that also had an uneven hospital-specific transition.

Chairman STARK. I appreciate that. That is what I was going to get at.

Congress tends to do simple things and you guys tend to make charts that complicate it. What is the danger in our just moving that transition out longer because we tend to play with these aggregates, right, Gramm-Rudman, budget considerations and we sit in conference and say, well, you guys are talking spending $25 billion and change and the old rules were $35 billion and change; why don't we split the difference and go to $30 billion and we can go 5 or 6 years instead of 7?

What do you see as the danger of doing that? Is there something unique about your program that has to stay at the 4 years or can we just add a little bit? Can we richen yours up? Suppose we want to save more, cut it down? Is that the adjuster we should use?

Mr. HELMS. I think I am correct in saying, yes, you could lengthen the transition. You would probably have more—if you just want to pay out more by making it uneven rather than even, that is where your bucks really change.

Chairman STARK. You mean by going to hold-harmless things.

Mr. HELMS. Yes, and paying a higher proportion on the hospital-specific amount.

But let me say one thing about the current policy estimates, too. You know, those are done by actuarial procedures and I am not criticizing them; they have to do it this way. But what they did was look at the historical rates of increase in capital expenditures and they assume 14 percent over 5 years.

Now, I read all these articles by all these experts who are saying already this year the bond sales are down. People are saying that in no way will Medicare be obligated to other people, but the actuaries have to do that.

Chairman STARK. If you took that last year on the bond sales chart, I don't think you would find much difference. That was both people participating an end to the goose and it had nothing to do with the needs of hospitals or any economic sense to it at all. We call it the "Pickle" factor.

I think, Dr. Helms, that that will cover it unless there is anything you would like to add. I guess there are a couple other things here.

Did you assume, or did the Department assume, put it that way, that taking care of this issue by regulation would thereby negate the need for the report Congressman Gradison was talking about?

Mr. HELMS. Absolutely not. Let me say there is no one who would like to get the report up here any more than I would. I will do my best to get it up here.

Having said that, let me say that most of the chapters in the report summarize a great deal of the technical things that we have already sent 1 year ago in those little red booklets.

But also we do some analysis of options, then we have the recommendations. I have tried to play out what is in the recommendation chapter.

As a matter of fact, our testimony is taken off the word processor right out of the chapter, and most of what you will get when you get that will be the recommendations.

Chairman STARK. I suspect, if I can correctly judge the mood of the subcommittee, that we will be legislating or at least recommending legislation in this area, and I also concur with my distinguished ranking member. As you may recall, I don't like freezes and I don't like postponements because we are not then doing our job. I voted against Gramm-Rudman. That is why we are not doing our job right.

If we could get the options considered, and if they could be quantified to the extent that they do not—I don't want you to disclose internal policy, but it would help our staff and whatever markup deliberations, and perhaps cause us to discard some you found would be not very helpful and we will probably ask you back on an informal basis to discuss with members and the staff some of the objections raised as we go through.

It will help us in our process. Dr. Bowen indicated to Congressman Gradison and myself that he looks forward to a lot more cooperation between the Department and this subcommittee and that would be a wonderful way to begin it. OK.

Mr. HELMS. Very well. Let me pledge I will do everything I can to get the report up here.

Chairman STARK. Or just pieces of it.

Mr. HELMS. And also the Secretary, too. But on the options, even those we have not analyzed, we will do our best to help you analyze those.

Chairman STARK. Thank you very much. We appreciate your testimony today.

Our next witness is Mr. Jack Owen, executive vice president of the American Hospital Association.

Mr. OWEN. Thank you, Mr. Chairman.

Chairman STARK. Before I ask Mr. Owen to proceed, I would like to at this point to address some remarks to the other witnesses who are in the room.

The time constraints of this subcommittee, because of the agenda of the full committee and uncertainty of our legislative program, have been tighter than we would like. Because of the time schedule set by the proposed rulemaking by the Secretary, we have been somewhat anxious to get specific information.

Many of the associations represented in this room asked to talk generally. We selected the American Hospital Association as the broadest membership association without any preemption of anyone else and then asked for hospitals in particular to bring us numerical data.

After Mr. Owen's testimony, we are going to strictly enforce the 5-minute rule on witnesses for summation of their prepared testimony.

It is the Chair's intention at that point to then allow the members of the subcommittee as much time as they feel necessary to question the witnesses hopefully about specific figures that they have presented to us. Then we can have other groups who insisted, for one reason or another, to be heard on issues that are related to this. It was done with the concurrence of the members of the subcommittee not in an attempt to cut short the testimony, but to try and get to some of the kinds of issues that we and the staff feel need to do a better job to serve you.

I hope the witnesses will bear with us and cooperate in that matter.

Having said that, Jack, welcome to the committee. You may proceed in any manner you see fit.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman.

I realize you are under a time constraint and I won't read my testimony. I assume it will be part of the record.

I would like to just comment on that and then see what questions you may have.

I am Jack Owen, executive vice president of the American Hospital Association, director of the Washington office.

I think this hearing is most timely and I just left a Brookings Institution conference on the problem of rural hospitals and the issue of what is going to happen to the rural hospitals, and the problem of capital is one that is of primary concern, certainly the standby costs in the swing-bed concept, and what may happen.

The PPS that we are all engaged in recognized that hospital capital costs differ from operating costs and Congress wisely asked for a study which has never been issued.

I find it highly interesting that the previous witnesses talked about the ample warning that hospitals had in 1983 regarding capital expenditures, and yet it seems like the Department also had ample warning to come forth with a report by October 1984, and we have not seen that either.

When we started this program, we were under the impression there would be an increase in the operating costs of market basket plus the technology factor. Before we finished the first year, the technology factor, capital factor was cut by three-quarters of a percent and we see what is happening to the operating costs and prices in the last 2 years.

As Congressman Gradison pointed out, it is not easy to make a capital decision and replace it and put it in service. There are long-term commitments that go with that.

It is usually a 3- to 5-year period before you can start a capital project and get it completed. Even in those States that had a tough certificate of need law, there was a period of time in which you must go through the process before you can actually get that capital project in operation.

I would like to talk about four things, if I could: the transition, adequacy of payment, the administration's proposal, and then just a conclusion of where we are coming from.

First, the transition: I think there have been a number of questions raised about the transition and the problem that creates. As you know, capital costs vary widely per hospital. It has no relationship whatever to hospital efficiency. They are usually long term in nature, 20 years, with about a 10-year midlife.

Operating costs can be altered over the short time. We have seen that hospitals have done that. I think it has been remarkable what occurred in the past few years under the PPS. We have seen cutbacks in staff, cutbacks in length of stay, cutbacks in the resources that are being used.

However, managers cannot make short-term decisions to reduce the capital outlay. They have already committed themselves to that million dollars or $20 million, whatever the case may be.

One cannot reduce the work hours or lay off equipment. Only decisions that play out over a period of time can reduce capital costs.

Major changes in Medicare, with PPS, incentive benefits we are realizing from those PPS changes, can be negated easily without some adequate transition to allow for those hospitals who need an exemption who have moved forward and have a high financial debt.

One thing I think we must point out again about adequacy is that, even if we have a good transition, if the adequacy of the capital payments are less than satisfactory, then a transition is of no help whatever. Current levels must be used as a starting point. Incentives for future growth should only be effective in the future years.

The most recent year that we have should be used and it should be updated annually. That technology factor must be included.

It was interesting to hear HHS representatives talk about the increase in the capital payout. But as I heard them say in 1983 it was a $3 billion figure and in 1985 it was going to be $3.8, in 1984. That is not much of an increase as we saw on some of the charts.

I think part of the problem that we are seeing here is that the total capital outlay is being referred to as a ratio of what the operating expense is and as length of stay and admissions go down, the capital cost stays where it is.

The administration's proposal that we have heard and seen today will create havoc in the hospital field. Four-year transition is just too short. It is not going to be able to take care of those hospitals that have some large-scale debts that have gone into this before 1983 and some have gone into it after 1983 in order to meet rules and requirements and regulations for fire and safety.

Any basis on the 1983 costs are too far in arears. The elimination of the return on equity, funded depreciation, reduces the debt, and as I heard the statements being made, there were savings going down in the capital budget of each year.

We recognize that you cannot replace capital for the same prices you fund depreciation today. There is a replacement cost and even with 4-percent inflation factor, you can't buy a table for $100 today and 5 years from now it is $120 and you funded $100, you won't be in the same spot that you were when you wear out that table.

These budgetary cost reductions from capital are unrealistic and will create real problems for hospitals to avoid defaulting on bonds.

We must look to Congress. We must look to you if we expect hospitals to continue to serve the Medicare population. That is what we are in business for, not to save the hospitals; we are there to serve Medicare.

I would like to just comment briefly on that bond financing that was talked about and our statistics show that a good bit of that bond activity, 41 percent to be exact, is refinancing. That is in the best interests of the Government.

Where we were financing at 10, 11, or 12 percent, earlier in the 1980's, we were able to cut that back to lesser interest rates.

There is only one thing we agree with the administration on is that we see no need for planning under 1122 as well. There has been a sharp decline in capital expense over 1984. You notice on our testimony there is a 10-percent drop from November 1985 to 1984.

In conclusion, Mr. Chairman, I would just like to say that from the overall standpoint representing all different types of owners and sizes of owners and kinds of hospitals, we feel that the capital program must be current, the prices, the dollars must be current.

There must be exceptions if it is going to be looked at so that the outliers, as was mentioned, might be one way to go; or, there is some hold harmless.

It looks to us like what the administration is talking about is holding harmless any movement toward higher rates, but if you go over, it is too bad, you can sink or swim.

Second, we think that the budget reduction process must not be used in the capital arena. It is not the place to do it. Reducing return on equity and reducing funded depreciation—we have even

heard comments about the possibility of donated assets being reduced. That has got to be stopped.

We would like to see that the Secretary's power be limited, so that they cannot come out and issue these regulations without taking into account all of the things that we talked about here.

Finally, that the transition must be adequate. We think it should be a 10-year transition period, that 4 years is much too short. If those things can't be met, it seems almost that we would have to be asking for an extension to continue what we are doing as a cost passthrough. We don't want to see that. That is not what we are here for.

We are particularly concerned that in the current fiscal environment, these changes will be used as a deficit reduction device with catastrophic financial impacts on those hospitals that have recently incurred or may soon incur necessary capital expenditures.

In view of the substantial reliance of hospitals on sources of capital, use of capital payments to help achieve deficit reduction goals could substantially affect investor confidence in the hospital industry investments, thus unnecessarily leading to an industrywide increase in the cost of capital.

With that, I would conclude, Mr. Chairman, and be happy to answer any questions you may have.

The witnesses following me will be giving you specific instances of problems in those institutions that they represent.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS ON MEDICARE REIMBURSEMENT FOR CAPITAL EXPENSES FEBRUARY 24, 1986

SUMMARY

The AHA believes that any specific plan to change the method by which hospitals are reimbursed for their capital expenditures should be based on the following four principles.

First, hospitals should be reimbursed at a rate adequate to support their current commitments. Hospitals should not be penalized for commitments made before changes in capital reimbursement are imposed.

Second, any new payment policy should be phased in over a period sufficiently long, 10 years at a minimum, so as to assure adequate and fair capital payments to meet individual institutions' needs.

Third, the amount of capital to be incorporated into prices must reflect current spending levels. The base year should be the most recent year for which data are available, and updated to reflect real increases in capital costs.

Fourth, any changes made in capital reimbursement policy must be made by Congress rather than by the Administration through regulation. The Administration's proposal for capital reimbursement, insofar as it has been revealed, is based simply on achieving short-term budget savings rather than on establishing sound policy.

INTRODUCTION

On behalf of its 6,100 institutional members, the American Hospital Association (AHA) welcomes this opportunity to comment on the issue of Medicare capital reimbursement. AHA particularly appreciates the interest that Congress has shown in this issue and its willingness to find a legislative method of changing the current system.

BACKGROUND

When Congress in 1983 first considered a Prospective Payment System (PPS) for the Medicare program, it understood that capital costs were significantly different from operating costs. While it devised and put into law a new incentive system to pay hospitals for their operating costs under Medicare, it

set aside any decisions on capital payments until October, 1986, and directed the Department of Health and Human Services (HHS) to study the issue and report back by October, 1984. HHS has not yet delivered the Congressionally mandated study, and has instead proposed as part of its Fiscal Year 1987 budget the incorporation of Medicare payments for capital into PPS.

CURRENT COMMITMENTS

A key issue that Congress should recognize is the nature of current capital commitments. The time between deciding to replace a plant and actually putting it into service easily can be from three to five years. Funding mechanisms such as bonds and mortgage funding are long-term commitments obligating hospitals for 20 to 30 years. Major equipment purchases have a life of 10 or more years. When these commitments were made, hospital managers properly counted on a certain level of reimbursement from Medicare to honor the Medicare portion of these debts. The ability of hospitals to repay existing debts will be severely hampered if the level of capital reimbursement is dramatically reduced while their debt service costs remain the same. Any payment scheme accepted by Congress must recognize these prior commitments made by hospitals.

TRANSITION

When considering major changes in the way in which the Medicare program pays for capital costs, the structure of these costs must be fully understood. Capital costs can vary tremendously over time for a particular hospital, depending on the overall average level of investment in capital or on whether it has recently undertaken a major investment. High capital costs in any given period may simply reflect a recent major investment and have no relation to whether a hospital is operated efficiently. Capital costs are long-term in nature and follow an extended cycle unique to each hospital. In general, this capital cycle is 20 years, with a 10-year mid-life. Therefore, to avoid major disruption in hospital capital financing programs, the payment system should be phased in over a period of at least 10 years. A phase-in period that is

sympathetic to current hospital capital cycles will help ensure that capital policy is adequate and fair.

While hospital operating costs can be altered relatively easily over the short term, managers cannot make short-term decisions to reduce capital outlays. One cannot reduce work hours or lay off equipment as can be done with staff. Simply changing resource use does not relieve payment of debt.

Only decisions that play out over time can reduce capital costs. Movement from a cost pass-through reimbursement method to a consolidated price payment method constitutes a major change in Medicare payment policy--so major, in fact, that the administrative and incentive benefits realized from such a change can easily be negated if an adequate transition mechanism is not included. Hospitals making major capital expenditures incur financial obligations over extended periods of time. Absent an adequate transition mechanism, such hospitals are unlikely to be able to satisfy these obligations and future access to capital will be jeopardized.

The transition mechanism should be structured to recognize and account for the needs of those hospitals that have recently incurred significant costs for facilities not yet in use, or that may soon incur such obligations because of code and standards compliance requirements and capital requirements associated with increases in community service needs.

ADEQUACY OF CAPITAL PAYMENTS

AHA's fundamental concern is that capital payments be adequate to meet hospitals' existing and future capital needs. Current spending levels should be used as a starting point, and if incentives to reduce future growth are established, they should be effective only for future years.

To reflect real hospital capital costs, when devising a formula for reimbursement, the most recent base year possible should be used. In addition, all capital costs that have traditionally been reimbursed under

long-standing Medicare policy should be a part of that base. To remove these costs from the base would penalize hospitals unfairly and limit their ability to meet existing obligations.

Beyond initially incorporating capital payments at current spending levels, in future years the consolidated Medicare price should be updated annually using an expanded hospital market basket that includes weights and factors pertaining to hospital capital costs.

Finally, an explicit, minimum technology improvement factor should be applied in annually updating consolidated prices to recognize increases in both capital and operating costs associated with certain types of medical technology improvements.

ADMINISTRATION PROPOSAL

The Administration's budget calls for incorporation of capital payments into PPS through a regulatory proposal that, in its current, draft form, violates all the principles established by AHA for a workable capital plan.

HHS plans a four-year transition, considerably shorter than the 10-year transition considered essential by the hospital industry. After the transition is complete, the HHS plan would result in payments based on 1983 costs, which fail to adequately recognize the changes in capital costs over the past three years and the life of the transition. The proposal also eliminates from the 1983 base several important elements, including return on equity, interest on funded depreciation accounts, and donated assets. These adjustments erode the base-year funding pool solely for budgetary reasons. The capital update factor, which would be used to project 1983 actual costs to 1987 levels, bears absolutely no relationship to the actual increase in capital costs over this period and underscores the clear intent of HHS to use this formula to reduce budget outlays.

The HHS draft proposal, expected to be published in June, also contains a

variety of caps on the hospital-specific portion of the payment formula restricting growth to 1986 levels. Such caps again are proposed for budgetary reasons and fail to anticipate that some hospitals must increase capitalization for public health reasons.

It is clear that if this nation's health care delivery system is to continue to have the ability and capacity to serve the Medicare population and others, we must look to Congress for a balanced solution to the problem of capital.

HEALTH PLANNING

As a final point, AHA believes that a federal role in state capital expenditure regulation is no longer necessary. Whether or not Medicare capital payments are incorporated into DRG prices, recent moderation in hospital capital spending demonstrates that hospitals are responding to changes in health services utilization and to the efficiency incentives inherent in Medicare and other payment systems. Rates of increase of hospital capital expenses for community hospitals have been lower in 1983-1985 than they were in 1981 and 1982 (see attached table). Most notably, the change in capital expenses in the first 11 months of 1985 compared to those in the first 11 months of 1984 is 12.2 percent, over 6 percentage points lower than the rate of increase in capital expenses in 1984 compared to those in 1983.

The percent change for capital expenses in the quarter ending November 1985 compared to those in the quarter ending November 1984 is 10.0 percent, an even sharper decline in the rate of increase of hospital capital expenses. Given this clear indication of moderation in hospital capital spending, federal sponsorship of the Section 1122 review program and involvement in state CON programs should be terminated. In addition, any attempt by HHS to impose Section 1122 requirements should be blocked by Congress.

CONCLUSION

AHA believes that if capital payments are to be incorporated into DRG prices, capital and aggregate DRG payments must be adequate and equitable from the standpoint of the individual hospital.

Congress should establish any new payment policy and, if it is unable to agree by the October 1, 1986 deadline, should continue the current payment system through a short-term legislative extension until permanent legislation is enacted into law.

Any new payment system should be be phased in over at least 10 years, recognize and account for hospitals' current commitments, and be based on the most recent costs and reimbursement policy possible.

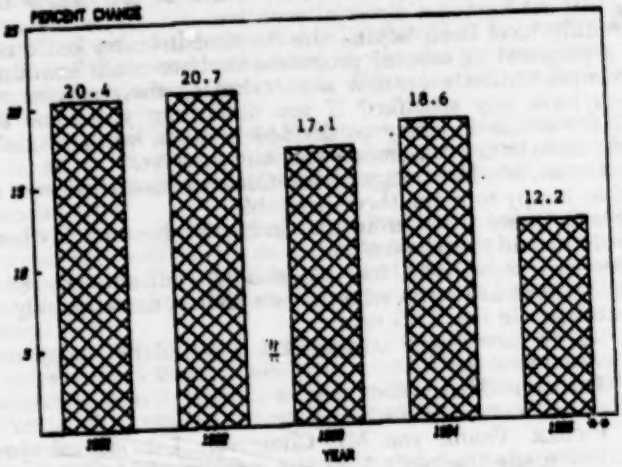
AHA is particularly concerned that, in the current federal fiscal environment, changes in Medicare capital payment policies and methods will be used as a budget deficit reduction device, with catastrophic financial impacts on those hospitals that have recently incurred or may soon incur necessary major capital expenditures. In view of the substantial reliance of hospitals on debt sources of capital, the use of capital payment to help achieve deficit reduction goals could substantially affect investor confidence in hospital industry investments, thus unnecessarily leading to an industrywide increase in the cost of capital.

Finally, AHA believes that, beyond the issue of capital payment, several fundamental concerns with the DRG system itself must be addressed in order to assure that aggregate Medicare payments to hospitals are adequate and equitable and, thereby, that Medicare beneficiaries are well-served.

RATE OF INCREASE OF HOSPITAL CAPITAL EXPENSES*

FOR COMMUNITY HOSPITALS

1981 - 1985**



* DEPRECIATION AND INTEREST

** FOR 1985, FIGURES REPRESENT PERCENT CHANGE FOR THE FIRST 11 MONTHS OF 1985 COMPARED TO THE FIRST 11 MONTHS OF 1984 (NOT LEAP YEAR OR SEASONALLY ADJUSTED). THE PERCENT CHANGE FOR CAPITAL EXPENSES IN THE QUARTER ENDING NOVEMBER 1985 COMPARED TO THOSE IN THE QUARTER ENDING NOVEMBER 1984 IS 10.0 PERCENT, AN EVEN SHARPER DECLINE IN THE RATE OF INCREASE OF HOSPITAL CAPITAL EXPENSES.

SOURCE: AHA NATIONAL HOSPITAL PANEL SURVEY

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Owen, I want to thank you for your testimony. I share your concerns. I think from a point of view of this committee with the time constraints that we are under, and October 1 isn't that far off, the best way of dealing with this if we are going to—is to come up with something very specific. I don't think we can deal with something without having a direct alternative.

I frankly have been hoping the hospital industry could come up with a proposal or several proposals that we could examine since the administration even now is not sharing their options with us. Do you have any specifics? If you don't, can you come up with some? Or is the industry so divided between winners and losers that we have to try to hammer this out ourselves?

Mr. OWEN. We have suggestions, Congressman Gradison, and we would be happy to make those available.

There is some division in the industry. I would be less than truthful if I said there wasn't.

There are some who feel we should continue the cost pass through. There are some who feel we should move quickly toward just putting it in the DRG rate.

But we do have some suggestions. I would be happy to make those available to you.

Mr. GRADISON. Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you Mr. Chairman. Let me ask you, Mr. Owen, you made the point that the amount of capital that would be incorporated would affect current spending levels, they should reflect the recent level. Does the former administration propose to use those?

Mr. OWEN. No, they don't, Congressman. What they are doing in effect is reducing what the current level of payment is even if you go back to 1983 taking into account the fact that a loan may have been made in 1983. If you reduce the return on equity on the hospital-specific side and reduce the depreciation, funneling depreciation offset, you are lowering that amount of dollars so that that hospital is in a position that it made a commitment which it was going to be paid a certain amount of dollars and those have been reduced.

If you look at the formula even on the way they move forward on their update, it is not keeping up with what actually was occurring in the use of capital in the past 3 or 4 years, and on top of that they have a lesser payment of whichever is the least amount, so that a hospital loses even if it has done a good job.

Mr. PICKLE. We have asked the administration to give us these cost figures, their proposal for reimbursement procedures. Now they have done it, whether we accept it is something else.

They proposed it to us by administrative decree. Why do you object to that? You said you think it ought to be done by the Congress specifically.

Mr. OWEN. For a couple of reasons. One, I think that Congress asked for a report which it never received, and so you really didn't have an opportunity to see what they were going to do; secondly, the way the administration is working this particular capital subject is through a budgetary cutback rather than on what might be

considered health policy, and the need for capital in the long run to provide for medicare services for institutions.

We think that Congress should be concerned and should be interested to make sure that their protection of those beneficiaries continues.

Mr. PICKLE. Were you here for the presentation of the chart on the bonds and all the rest?

Mr. OWEN. Yes, sir.

Mr. PICKLE. I asked the question why should it be such a large increase. It is 2½ times almost what it was the previous year, and 10 times what it was 5 years ago. Why is that such a large number?

Mr. OWEN. One of the biggest things we found out in looking at the bonds, we did a survey of the hospitals who floated bonds, 41 percent were refinancing. So that they were really not new dollars in the capital field.

If you look back several years ago, hospitals borrowed at the rate, interest rate was 12, 13, as much as 14 percent on tax exempt bonds at one point. Many of those were refinanced and the reason they were refinanced in 1985 was because of what happened in the Tax Reform Act.

If you are going to do the refinancing you almost had to do it rather quickly. So I think there was a twofold pressure, one to do the refinancing, one to get it done before the changes occurred.

Mr. PICKLE. Why would just suddenly in the year 1985 everybody try to refinance?

Mr. OWEN. For two reasons, one is if you can save some money on your interest rate it is always a more prudent thing to do.

I think number two that most hospitals who had either safety or regulatory problems that must be corrected looked at it and said we better move more quickly than we would have under a normal planning process.

Mr. PICKLE. And it all happened in 1985.

Chairman STARK. If I may correct the record if I may, just for one second, the administration's chart and testimony excluded refinancing. That was all new issue.

Mr. PICKLE. Did they?

Chairman STARK. In their chart, it says as big as all outdoors, excluding refinancing. It may not make all the difference in the world, but their testimony did say that.

Mr. PICKLE. The chairman is right.

Hospital bond issues excluding refinancing.

Now, would you want to revise and extend your remarks?

Mr. OWEN. Let me say, the aggregate dollar volume in hospital bonds in 1985 was $19.44 billion. Now that is a big increase; no question about that.

Of that $19.44 billion, 41 percent was in third quarter 1985 for refinancing.

The interest rate on hospital bonds dropped from an average of 10.61 percent in 1984 to an average of 9.64 percent in 1985.

They have dropped down even since then. So the figures that I have got are on—I couldn't see all their figures from back there, are what the actual hospital bonds were. I don't know if that included public bonds or whatever else they have had in there. But

there was a definite increase, no question about that, a big increase.

However, there has been no bonds issued since the first of the year to our knowledge.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. Mr. Daub.

Mr. DAUB. Mr. Chairman, thank you very much.

Jack, thank you for being here. I read your testimony as well as heard your oral remarks. I paid attention to the conclusions. You are being rather general yourself at this point if I may suggest, and I had not only the chance to study this issue pretty carefully, but to commend to the others in the room who may be simply learning about this process for the first time, a publication by Ernst & Whinney, an accounting firm, a very excellent little pamphlet that really puts together the ideas.

Let me ask you a quick question about hospital specific. If you had a 7-to-10-year phase to a national rate and inclusion of capital costs in the rate, 7 years would be more acceptable than 4 and, of course, 10 would be more acceptable than 7. But a blended rate at 7—has your thinking progressed far enough to know whether that would work?

Mr. OWEN. We would like to see 10 very honestly, because that covers just about from what we can tell about 95 percent of any exceptions. So if you get to 7 you are down to around 85 percent of the hospitals that would not have a problem.

The thing that I feel is as you move into this if the price is right as one goes into the national rates and takes that, no longer the passthrough or blend, they have no chance to go back. They have to in the future live out of the dollars which come out of the combination of operating and capital.

The real issue is how you protect those hospitals who have large debts until they can reach that point where they can manage in such a way so they can look forward to plan for future capital. In some of the southwest states and southern states and some of the big teaching hospitals primarily, there has been some large bond financings taking place, and the 7 years or so transition period is awfully quick.

Mr. DAUB. Wouldn't be quite enough.

Mr. OWEN. Right.

Mr. DAUB. There is a recognition relative to current commitments being made, particularly as bond capital is attracted, on how to amortize these funds and get the depreciation schedules worked out. I think that may be an admission to a degree of additional capital being attracted—with tax reform going on at the same time and the question of what we do with the tax deductibility and attractiveness of the bond for that financing purpose in the private sector.

I think if the HHS provision is budget neutral and the OMB provision intends quite honestly to cut the amount of Federal dollars that go into the capital cost passthrough, that it is really going to be important to this committee, as Mr. Gradison said, to have you all take a specific look, too, at the various proposals because as we move to October 1, the odds are we are going to get some kind of a decision and I would hope that we do something.

It may be an issue we cannot act upon because we don't have in-
rmation. But I really hope that you all will dig into it a little
ore as well.

Mr. OWEN. We will be happy to, and we have, and we will make
available.

Chairman STARK. Jack again, thank you.

Is there any question among your membership in general, and I
asn't quite as involved with this whole medicare issue back in
983, but it seems to me as I read the history that there was no
uestion in my mind that there would no longer be any cost reim-
ursement for capital after October 1, 1986.

Mr. OWEN. That is correct.

Chairman STARK. There isn't anybody running a hospital or any-
ody selling bonds around the country that thought there was
oing to be, is there?

Mr. OWEN. I don't think so. I think, however, we thought there
ould be a market basket and technology factor and other things
hat go along with it.

Chairman STARK. But was there anybody in general in the indus-
ry that thought we would continue cost-related payments after Oc-
ober 1, 1986?

Mr. OWEN. I couldn't, I don't know if I could go that far that
here wasn't anybody.

Chairman STARK. But not many.

Mr. OWEN. Not many.

Chairman STARK. I keep hearing people were surprised by that
nd I just think they may be disappointed, but I am not so sure
hat they could legitimately claim to be surprised.

Also, we hear a lot about the fact that hospitals do a lot of debt
financing.

I am going to suggest to you that that isn't unique to hospitals. If
you look at calendars for 1985, and Boone Pickens, for example,
nobody has issued any stock, the whole world has been debt financ-
ing whether it is through Master Charge, junk bonds, tax exempt.
It is just largely the tax code. I just suggest that in passing. I don't
know anyone who isn't debt financing today seriously. I don't know
why that should be so unique.

As I see the issue here, and I don't know quite how to do it, we
are paying through medicare for about, I am going to guess, 35 to
40 percent of your members' income.

Mr. OWEN. Correct.

Chairman STARK. Does that include capital?

Mr. OWEN. It is about 40 percent total.

Chairman STARK. Of everything.

Mr. OWEN. Everything, yes.

Chairman STARK. So that other customers, whether they are
buying under the old system or from the blues or these new pre-
ferred providers or HMO's contracting on a capitalization basis,
none of them generally speaking are providing any capital pay-
ments. They are just paying so much a procedure or so much a
head, is that correct?

Mr. OWEN. No, that is not correct.

Everybody participates in capital who pays. It is part of the
price.

Chairman STARK. But it is not separate. The price is quoted either per capitalization, so much a member, not plus something for capital.

Mr. OWEN. That is correct. That is part of the price.

Chairman STARK. If they are under a surgical schedule it is so much a day for a double room and so much a day for a private room, and so much for a procedure.

Mr. OWEN. Right.

Chairman STARK. Nobody else does it the way we do, so to speak?

Mr. OWEN. But we negotiate the price.

Chairman STARK. That is right. But I gather that that is what the administration is suggesting we are going to be doing with you when we get to a national DRG system, negotiate the price.

Mr. OWEN. If we negotiate the price, that is one thing. If the price is set for us, that is a different thing.

Chairman STARK. Well, I suspect that you negotiate the price and—negotiate the price in much the same way Ford Motor Co. negotiates with Dearborn Memorial. I am sure that Dearborn Memorial can tell the Ford Motor Co. they won't take their offer but I don't know if they can get any other customers.

So that could be the case. There could be some hospitals that don't want Medicare patients.

Mr. OWEN. But we cannot do that.

We cannot refuse the offer. That is why we need changes.

Chairman STARK. But if I had to guess we would go the other way and include more people who won't have the option yet.

In 1984 and 1985 you were about 6,000 hospitals?

Mr. OWEN. 6,300.

Chairman STARK. In any particular year, whether it is 1985 or 1984, can you tell me how many hospitals closed because of financial failure, went broke, if you distinguish that from running out of business.

Mr. OWEN. I can tell you we went down from a high of 7,200 to 6,300 hospitals but that is not all failures. That is a lot of mergers and a lot of—there have been a lot less failures than what was predicted. The problem there is now primarily in the rural parts of our country and that is what is going to happen in the next year or year-and-a-half with the frozen DRG.

Chairman STARK. Would 10 or 20 financial failures be a good number, where they defaulted on bonds or went into foreclosure?

Mr. OWEN. I know of no one who defaulted on bonds. There may be some. I know of none. I don't think there were any more failures than there was before the DRG system started very honestly.

Chairman STARK. There weren't many failures then either, were there?

Mr. OWEN. No.

Chairman STARK. How about new hospitals opening? Not counting mergers.

Mr. OWEN. There have been very few in the last couple years only in some areas where you have seen population switches, growth areas, a few there. But the actual number of new hospitals has declined dramatically.

Chairman STARK. So if there is any change it might have been consolidation mergers, et cetera, but neither a great deal of disappearing nor a great deal of new ones being built.

Mr. OWEN. Right.

Chairman STARK. Well, I appreciate your testimony, Mr. Owen. As I say, I suspect it is the sense of the committee that this transition is going forward. I think the committee would assume working with your industry, to make that transition. I gather that the major issue is transition. I don't think in a realistic sense—I say that in a political way—that it will be anywhere near 10 or 20 years. That hardly seems like a transition.

That seems like a career.

Mr. OWEN. Twenty is a little long. Ten is all right.

Chairman STARK. Let me ask one last question. As I asked the Secretary, are you content if we just fudge that number? Do you see any danger? I think I was correct in saying the administration originally intended 7 years.

Mr. OWEN. Yes.

Chairman STARK. It was rejected by OMB. If they had gone to 7 years and I am not sure that Dr. Helms said this, but I will infer that in his testimony, the 7-year transition had paralleled existing law in terms of aggregate numbers. By cutting it down we cut it by about a good 20 percent for the first year plus flatten it out, which means a substantial cut over the period.

Would you be content to seeing this committee fiddle with the numbers without going to specific relief like outlayers and hold harmlesses? Or would you rather see us get into a whole complex system——

Mr. OWEN. I would like to see you look at the transition but don't forget adequacy of the rate. Because if you get 10 years transition and give us only half the capital being spent, you haven't helped us a whole lot. So you have to look at the adequacy.

Chairman STARK. But in none of the testimony today—some I have seen but some I haven't—does anyone talk about raising the price to the other customers. That always seems to be a partial cure. I don't know that——

Mr. OWEN. I am not sure I follow that. Because the price is raised to the other customers.

Chairman STARK. I am suggesting on all the printouts we will see the inadequacy of capital doesn't take into account perhaps raising the flat price to the private insurers or to people without insurance. We have no jurisdiction over that. I am not sure any of us want to vote consciously to raise the price of private health insurance around the country.

Mr. OWEN. I am not asking for a raise, I am just asking to protect what has been done so if in future years the incentive is there, managers have an opportunity to make wise decisions on what will happen in the future. That is different than making a decision on what occurred in the past.

Chairman STARK. You talk about adequacy, maybe I am missing the point here, but there has been no discussion about letting two-thirds of the people pay for medical care that are not being paid for by medical care raise all their costs. All the projections will keep that pretty much flat. That is an alternative. I am not sure it

is the right one, but it has not been discussed. Wouldn't that logically follow?

The hospital has two choices, goes out of business or raises the price to other customers.

Mr. OWEN. That is right.

Chairman STARK. It wouldn't dare cut quality of care, would it?

Mr. OWEN. Nope.

Mr. DAUB. If you would yield, I thank the chairman for yielding

Chairman STARK. Mr. Daub.

Mr. DAUB. Did you want to pursue or elaborate on the tail-end to your answer to the chairman on hospital closings that you didn't have any way of evaluating what would happen with the comin freeze in the rate?

Mr. OWEN. That is right. We are——

Mr. DAUB. Are you concerned about that?

Mr. OWEN. Very concerned, especially in the more rural areas o our country, Congressman, where the standby costs are high, th occupancy rate is down, and there may be some mergers, ther may be actual failures. We are also concerned about the inner cit hospitals and the problems created there. To date, we have n seen a rash of hospital closings.

Mr. DAUB. Do you project that locking of the rate rather tha continuing to move it as planned to the national rate could crea disproportions that would cause those very things to happen?

Mr. OWEN. I think it definitely could. Two things could happe access and quality of care could be affected. Even with a small i crease in the cost of living at 4 percent when you start freezi hospital rates at zero, over a couple years you are behind 8 perce to start with when you start out again.

Mr. DAUB. Thank you.

Chairman STARK. Thank you very much, Jack. We apprecia your testimony, and look forward to working with you.

Mr. OWEN. As we have been in the past, we hope to be help and cooperative in the future.

Chairman STARK. The next witness is John R. Lauri, administ tor of the Miami Heart Institute.

STATEMENT OF JOHN P. LAURI, ADMINISTRATOR, MIAMI HEA INSTITUTE, REPRESENTING MIAMI HEART INSTITUTE, SINAI MEDICAL CENTER, ST. FRANCIS HOSPITAL, AND SOU SHORE HOSPITAL

Mr. LAURI. Thank you, Mr. Chairman.

Chairman STARK. Mr. Lauri, first of all I wanted to thank for providing your testimony to the committee in such a tim fashion. It makes our job much easier. You will be blessed w that funny light in front of you. We will try not to make it dist your testimony.

If you would proceed to summarize in any way you wish, y prepared testimony will be inserted in the record. The mem would like to run through it at greater length with you in q tions. Proceed in any way you are comfortable.

Mr. LAURI. Mr. Chairman, distinguished committee members me say thank you for the opportunity to be here today to pre

our testimony. My name is John Lauri, administrator of the Miami Heart Institute.

I am accompanied by Mr. Sam Traina, our chief financial officer. I am here to testify on behalf of four Miami Beach hospitals: the Miami Heart Institute, Inc., a 258 bed adult medical/surgical hospital concentrating in cardiovascular disease; Mount Sinai Medical Center, a 699-bed major teaching hospital; Saint Francis Hospital, a 273-bed community hospital; and South Shore Hospital, a 178-bed community hospital.

Miami Beach, as you are probably well aware, is one of the largest concentrations of elderly Americans throughout the country. According to the 1980 U.S. Census, 51.8 percent of Miami Beach residents were over age 65 as compared to 11.3 percent for the Nation as a whole. In addition, 17.7 of those over 65 years of age are living below the poverty line.

Reflective of the Miami Beach age composition, the hospitals in Miami Beach provide one of the largest volumes of Medicare services of any group of hospitals from the same service area. We have been historically above the national average in percent occupancy in our hospitals and in 1985, 67 percent of our patients collectively were Medicare patients.

A well-documented fact within our institutions is that we serve a disproportionate share of the elderly who are older and sicker people. Our hospital last year had 80 percent of its patient days Medicare. South Shore Hospital had more patients age 85 and above than they did under 65. We obviously serve a very unique population in our country.

In the late 1970's and early 1980's all four beach hospitals proceeded with developing long-range plans for facilities modernization and replacement. I emphasize that as opposed to expansion or addition of beds.

During the course of the years subsequent to that, three of the four hospitals proceeded with projects that would in fact allow for that type of replacement to occur.

Our project has a Certificate of Need issued in December 1980. In early 1981 we proceeded with construction and related activities to that project. In September 1982 we had a tax-exempt bond issue for our hospital in the amount of approximately $43 million.

In 1985 we were substantially completed with that project the first year in which any substantial dollars were realized within our reimbursement program. A point that you should take very significant cognizance of is the fact that under the current proposal it would not be in our base year.

There is obviously, from our perspective, a very significant inequity in the proposals presented to date.

The comments made by HHS saying that we were warned far in advance are far from ample. Our capital costs of the beach hospitals today are: Miami Heart Institute, 19 percent; Saint Francis Hospital 18 percent; South Shore Hospital 16 percent; and Mount Sinai 8 percent. You should also note that Mount Sinai has a $100 million planning program on the boards that they have put on hold because of the warning given in 1983 for impending changes in the capital reimbursement for Medicare.

Saint Francis has stated that their project in fact with a 6 pe cent add-on, which is what our testimony was developed on befo the OMB proposal, would force them into a situation of default o their bond issue within 3 years.

Obviously these are significant dollars. To translate those pe centages into dollars and give you hard facts, all four of our hos tals with the current prospective payment system and propos capital add-on which we present in our testimony would have combined loss from operations in 1987 of $27.6 million, in 198 $39.9 million, and in 1989, $43.5 million.

For our hospital alone it would be $8.6 million, $9.2 million a $9.8 million. Obviously the proposals before you do not respond to planning process that was undertaken prior to 1983 in our partic lar situation. I don't think it is unique to south Florida in th there are hospitals throughout the country that have significa capital costs they must deal with.

We think a program should be developed that allows for tho projects that were approved prior to April 1983, to continue to paid on a cost-reimbursed fashion as was the method when we tained all the approvals and permits required by Congress to Medicare reimbursement. And, that we would strongly suppor prospective payment system for future capital projects in a prosp tive manner as was intended by Congress.

Finally, I would say it is our strong feeling that the decisionm ing on that process should be handled by Congress.

Mr. Chairman, thank you for the opportunity to be here. I be more than happy to respond to any of your questions.

[The prepared statement follows:]

STATEMENT OF JOHN R. LAURI, ON BEHALF OF THE MIAMI HEART INSTITUTE, MOUNT SINAI MEDICAL CENTER, ST. FRANCIS HOSPITAL, AND SOUTH SHORE HOSPITAL

INTRODUCTION

Mr. Chairman, members of the Subcommittee on Health of the Committee on Ways and Means of the United States House of Representatives, I want to thank you for the opportunity to present testimony today on the proposed Medicare reimbursement mechanism for capital costs.

My name is John Lauri. I am the Administrator of Miami Heart Institute, Inc., 4701 Meridian Avenue, Miami Beach, Florida 33140, Telephone (305) 674-3044, a 258 bed adult medical/surgical hospital concentrating in cardiovascular disease. My presentation will represent the views of our hospital as well as the three other not for profit Miami Beach hospitals, Mt. Sinai Medical Center, a 699 bed major teaching hospital, St. Francis Hospital, a 273 bed community hospital and South Shore Hospital, a 178 bed community hospital.

MIAMI BEACH AREA

Miami Beach, as you are probably well aware, is one of largest concentrations of elderly Americans throughout the country. According to the 1980 U. S. Census, 51.8% of Miami Beach residents were over age 65 as compared to 11.3% for the nation as a whole. In addition, 17.7% of those over 65 years of age are living below the poverty line.

MIAMI BEACH HOSPITALS

Reflective of the Miami Beach age composition, the hospitals in Miami Beach provide one of the largest volumes of Medicare services of any group of hospitals from the same service area. In 1985, our hospitals had an average Medicare occupancy rate of 67%. It should be noted that this disproportionately high precentage of Medicare patients is "older" and "sicker" -- a documented result of the demographics of our area as well as the facilities and services available through our hospitals. Because of the high Medicare utilization, our hospitals have consistently planned for the future with a strong knowledge and understanding of the impact of the Medicare program on our decision-making. In the late 1970's and early 1980's, all four hospitals undertook planning efforts to respond to the need for services within our area. The results of that process were that three facilities proceeded with major facility renovation and modernization projects. Each hospital received all required permits and approvals necessary for their projects, including a

Certificate of Need - a requirement for reimbursement of capital costs under the Medicare program. Those certificates of need were issued as follows:

1.	Miami Heart Institute, Inc,	- $62.8 million	12/16/80
2.	St. Francis Hospital	- $46.1 million	12/20/82
3.	South Shore Hospital	- $ 9.4 million	3/09/81

Mt. Sinai Medical Center's planning process resulted in an identified capital program for replacement and modernization in excess of $100 million. Unlike the other hospitals no commitment had been made for the implementation of this plan when Congress announced plans to change Medicare reimbursement. Thus, that project is essentially on hold.

MEDICARE PROSPECTIVE PAYMENT SYSTEM

In April, 1983, Congress publically indicated its intent to change the reimbursement system for the Medicare program. It was clearly a message to the health care industry that future payments for the care of the elderly would be different and that planning should be done with this in mind.

On October 1, 1984 the prospective payment system, known as DRG's, was implemented for the Medicare program. It did not, however, change the mechanism for reimbursing capital costs.

Today, your committee is hearing testimony on proposals to replace the existing mechanism which expires on October 1st, 1986. Mr. Chairman, it is the hope of the Miami Beach hospitals that the plan adopted will provide adequate funds, equitably distributed for hospitals to maintain their physical plant and equipment and meet their related debt service requirements at the level patients have come to expect and deserve.

It is our position that capital costs approved prior to April of 1983 when Congress first indicated changes were forthcoming, should continue to be reimbursed by the mechanism in place at that time. Any type of "DRG" add-on for capital costs should be applied on a prospective basis only.

INEQUITY OF PROPOSED CAPITAL COST REIMBURSEMENT MECHANISM

The Miami Beach Hospitals recognize the necessity for fiscal restraints and the budgetary burden faced by Congress. We also understand that the new capital cost reimbursement mechanism is intended to be budget neutral. In the absence of an equitable formula that responds

to the committments of the past, it is our recommendation that Congress retain the current system and, subject future capital costs to a more comprehensive health planning review.

The approval and implementation of a 6% add-on proposal (whether immediate or with a phase-in) which has seen substantial attention is not an equitable solution. Some hospitals would experience windfall gains while others would incur severe hardships. For Miami Beach, the latter would be the case.

Currently, capital costs for all of our hospitals exceed 6%. St. Francis is 18%, Miami Heart Institute is 19%, South Shore Hospital is 16% and Mt. Sinai - without their major capital project - is 8%. Taking into consideration the existing prospective payment system regulations and a proposed 6% capital cost add-on, the projected losses from operations for the Miami Beach hospitals would be devastating. In 1987, all four hospitals are projecting losses that total $27.6 million. Continued losses of $36.9 million and $43.5 million in 1988 and 1989 respectively would follow.

Clearly the viability of our hospitals under the 6% add-on proposal would be very questionable. This program could potentially result in a significant curtailment of services to the detriment of Miami Beach residents. I am confident that further investigation would find other hospitals with a similar situation under a 6% DRG add-on program.

CONCLUSION AND RECOMMENDATION

It is our position that an equitable mechanism must be established for reimbursing capital expenditures approved prior to April 1983. We also believe that the Congress is the branch of government that should act on such a major issue.

The health care industry is undergoing a phenomenal change at the present time. This is equally true for the Medicare program. Inasmuch as the Department of Health and Human Services has not been able to develop a meaningful and equitable plan as mandated by Congress, it is our recommendation that the current reasonable cost based system be retained with a more comprehensive health planning review for future capital expenditures.

Thank you for permitting us this opportunity to present our views on a subject of obvious major concern to the hospitals of Miami Beach and the patients we serve.

Chairman STARK. Thank you.

Are you talking about Miami Beach or do you mean your hospitals which you are representing today, have a 67 percent Medicare occupancy? You are referring to the group?

Mr. LAURI. That is correct.

Chairman STARK. In the same period of 1985, what was your overall occupacy roughly?

Mr. LAURI. For the four hospitals, I would suspect it was probably in the low 70 percent occupancy range.

Chairman STARK. So it is fair to say that 90 percent of your capital costs were being covered by Medicare?

Mr. LAURI. Sixty-seven percent is being covered by medicare based on our Medicare patient day proportion to total patient days. Are you calculating that back from assuming 100 percent occupancy?

Chairman STARK. It can't be higher than the percentage——

Mr. LAURI. Our hospitals had 67 percent of our occupancy by Medicare patients, so 67 percent of our capital cost reimbursement came from Medicare.

Chairman STARK. You are not saying that 90 percent of your patients were Medicare patients?

Mr. LAURI. No. In our hospital it was 80 percent last year.

Chairman STARK. The other question is you are talking about 18 percent capital costs and I have been led to believe that the national average is 6 or 7. Why would your costs be so much higher? Is that correct, the national average is around 6 or 7 percent?

Mr. LAURI. That is the information I have.

Chairman STARK. Why would your particular hospital be so much higher?

Mr. LAURI. Three of the four that have the high percentage of 19, 18 and 16 percent all incurred major capital projects in the early 1980s. Those were approved in the early 1980s, constructed and they have come on line and are coming on line during this last year or two.

Chairman STARK. I don't know, unless you had a tremendous population growth, what were the capital costs from 1970 to 1980, as a percentage?

Mr. LAURI. For those three hospitals, obviously much, much less. For our hospital, for example, prior to that project, was debt free. We had an old plant that had been directed by the HRS, the State licensing agency, to replace because of code deficiencies. Most of these projects were replacement projects. None added any new beds.

Chairman STARK. In other words, you are talking about a hospital cranking along that doesn't need all this capital payment, somebody built a new plant and new equipment, all those things, and that the payment that somebody would make at a competing hospital that didn't have this wouldn't be adequate to pay for—in other words, your prices, I presume, are the same as an older hospital nearby? Maybe there is nothing comparable in your opinion, but let's assume that there is another hospital that provides the same type of DRG functions to our beneficiaries. They may be getting actually less for each transaction because they will get the capital

payment and you can't exist with them. They are competing with a lower cost plan.

Mr. LAURI. It would be a difficult issue to compare, I think, from the perspective of one of our hospitals has the highest case mix index in the State of Florida given the nature of our patients so there is a severity index.

Chairman STARK. Let's assume that there is a hospital down the street and it is the—XYZ Hospital; it is old, it is in the same situation you were in pre-1980, but if a Medicare patient walks into your hospital or the older hospital down the street, each hospital gets the same DRG payment, but you get some capital reimbursement under the old system, is that not correct? So the Government in effect is paying more to have the procedure handled in your hospital than it is your competitor down the street?

Mr. LAURI. Theoretically, that is correct.

Chairman STARK. And I guess that is what we are here today to figure out. I mean you went ahead and I presume under rules that previous Congresses decided were proper and built a building. How do we, or rather you build any buildings after 1983?

Mr. LAURI. The certificate of need was issued in December of 1980. We started in 1981. We still have a small, small portion of that to complete, but the major portion was completed in 1985. It is just the time span of construction which I think is something that the committee needs to be very careful with when they set the base year if prospective payment is made.

Chairman STARK. Did you use your bonds to cover that?

Mr. LAURI. Yes, we did in September 1982.

Chairman STARK. And so the bond authorities made no mention of the prospective legislation?

Mr. LAURI. That is correct.

Chairman STARK. We didn't have any, but I assume they might have been talking about it then. I don't know. I wasn't on this subcommittee at the time.

Mr. Gradison.

Mr. GRADISON. I have no questions.

Chairman STARK. Mr. Daub.

Mr. DAUB. No questions. I appreciate the testimony.

Chairman STARK. I appreciate it and your specific examples will be useful to us. I gather what the subcommittee will attempt to do is find a transition or a way to fold the capital costs into DRG's that will minimize the pain to associations like yours and not, I suppose, provide excessive windfalls to the competitor down the street who didn't modernize. We will look forward to your help as we proceed in our deliberations.

Mr. LAURI. Thank you. We will be happy to make ourselves available to respond in the future if it is necessary.

Chairman STARK. Thank you.

Our next witness is James E. Raney, president of the Northern Michigan Hospitals, Inc. He is accompanied by Mr. Jerry L. Worden, vice president-finance; and Mark Littler, who is a trustee.

Mr. GRADISON. I would like to thank you for scheduling this next group of witnesses. They provide an extremely important service in a rural area of northern Michigan. While their service is not natu-

rally unique, I think it is representative of the problem of broad concern to all of us.

Thank you.

Chairman STARK. Is this peninsula or upper Michigan?

Mr. RANEY. We are the lower part.

Chairman STARK. Mr. Raney, welcome to the committee and why don't you proceed.

STATEMENT OF JAMES E. RANEY, PRESIDENT, NORTHERN MICHIGAN HOSPITALS, INC., ACCOMPANIED BY JERRY L. WORDEN, VICE PRESIDENT FOR FINANCE, AND MARK LITTLER, TRUSTEE

Mr. RANEY. Mr. Chairman and honorable subcommittee members, thank you for this opportunity of coming here today to express our concerns regarding the HHS-OMB proposals to integrate capital costs into the DRG payment.

I am Jim Raney and I am president of Northern Michigan Hospitals in Petoskey, MI. I have with me today one of our trustees, Mr. Mark Littler, and our vice president of finance, Mr. Jerry Worden.

We are here to present to you, I guess, the loser's side of the formula and we hope that we can act as a resource for you in developing policy in the future.

We are here to open our books and our facility to you to demonstrate to you that this policy as proposed will impact our institution greatly. The new rules will punish us for past capital acquisitions which were fully approved under 1122 legislation and rigorous State review.

Playing by the rules that existed in the past and with your consent, we built a unique medical center in a rural area of northern Michigan. We are very unique. As a matter of fact, if you consider our medical staff, we have over 100 specialty physicians, 84 percent of whom are board certified and we serve a population approaching 300,000. In addition, 60 percent of our patients are referred to our facilites from physicians not on our staff. In addition, 60 percent of the patients coming to our facilities drive more than 25 miles to receive our services.

Our patients also tend to be more acute, more severely ill. This is indicated by our case mix index in which we are among the top 5 percent in the State of Michigan and among the top 4 percent in the country.

In addition, we serve as a hub for nine small facilities in rural northern Michigan. Our system has evolved to provide high technology and specialty services that would otherwise be unavailable in our rural area. It is the same unique blending of high specialized referral care in a rural setting that was recognized by Congress in the Health Care Financing Administration in 1983 as being exceptional and special among other hospitals.

A special category of hospitals known as regional referral centers was created for facilities like northern Michigan hospitals and reimbursement enhancements were granted under prospective pricing legislation.

Our capital outlays over the last couple of years that have been considerable, but not ill advised because in every case we acted

within existing State and Federal rules or guidelines and with full approval of all required State planning agencies.

In short, we have become what we are today, a truly unique referral center with your full encouragement and approval and we believe that the 300,000 residents of northern Michigan are better off because they no longer have to travel 180 miles for specialty care.

This project did not come easily or inexpensively. Since 1977, over $50 million has been expended on capital and there remains $27 million in bond indebtedness due in 2007.

Our current annual capital costs therefore amount to 12 percent of our total operating budget of $43 million.

As you can see under the present HHS-OMB proposal, it would be very much devastating to our hospital. In fact, as we talked earlier, we would be a candidate for a merger or consolidation because under the current proposal we would not be able to pay off those bonds.

So the proposal in our minds is unacceptable as it is applied retroactively and based on a national average cost of 6.9 percent, a percentage addon that would amount to little more than half of our current annual capital expenditures.

Loss of millions of dollars to our hospital would result of the 6.9 percent. Since 59 percent of our patients are Medicare sponsored and considering the fact that the Medicare eligible population is growing an average of 6 percent a year in our area, lost capital investment will increase year by year.

We believe that in order to implement an equitable effective cost plan, three suggestions we would like you to consider.

One, we support Chairman Stark's recommendation that Congress get involved in the ultimate solution to the capital cost problem.

Two, in terms of a short-term solution, there should be a grandfathering of capital expenditures made prior to 1983 enactment of prospective pricing.

In terms of a long-term solution, a percentage add-on of DRG payments should be implemented for capital expenditures made after the effective date of the prospective pricing legislation.

We believe this will create a plan to allow the industry to adjust to new rules without being unduly penalized for abiding by the rules existing prior to PPS.

We have played by your rules and are willing to do so in the future, but we cannot and should not be expected to change midstep when long-term financing of these projects has been committed. We are asking for time and recognition of past approved actions. We believe that more than Michigan hospitals and our entire industry will then and only then be able to adjust to the percentage add-on for capital costs.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF NORTHERN MICHIGAN HOSPITALS, INC.

Honorable Representatives, Staff and Guests:

Thank you for this opportunity to share with you our concerns regarding the proposed capital cost plan as contained in the President's fiscal year 1987 budget. My name is Jim Raney and I am President of Northern Michigan Hospitals in Petoskey, Michigan. I have with me today one of our trustees, Mr. Mark Littler, and our Vice President of Finance, Mr. Jerry Worden.

We are desperately concerned about the rules being proposed by HHS and OMB because we believe that they will, if allowed to pass, be devastating to our hospital. These new rules will punish us for past capital acquisitions fully approved under 1122 legislation and State Certificate of Need guidelines. Playing by your rules and with your consent, we built a unique medical center in rural northern Michigan. It seems unreasonable that you would now choose to dismantle a facility that you, in fact, helped to create.

Northern Michigan Hospitals began as the dream of a young medical student determined to bring high quality, specialty care to rural Northern Michigan. That dream became a reality in the early 30's and since that time our hospital has become one of only a handful of unique, referral hospitals in rural areas of our country.

We have a medical staff of over 100 specialty physicians, 84% of whom are Board Certified and serve a population approaching 300,000. Fully 60% of our patients are referred to us by physicians not on our medical staff and over 60% of our patients come from 25 miles away or more to receive care at NMH. Our system has evolved to provide "high-tech" services that would otherwise be unavailable in our rural area.

It is that same unique blending of highly specialized, referral care in a rural setting that was recognized by Congress and the Health Care Financing Administration in late 1983 as being exceptional and special among all other hospitals. A special category of hospitals - Regional Referral Centers - was created for facilities like Northern Michigan Hospitals and reimbursement enhancements were granted under PPS regulation.

But our unique status was defined even before PPS, when the State of Michigan Health Planning Body called upon NMH to regionalize neonatal intensive care for an 18-county region. With State Planning Agency approval and under the guidelines of 1122 legislation, NMH undertook projects to improve patient access to sophisticated medical technology and treatment. These included our areas first and only open heart surgery program, linear accelerator for cancer treatment, and the nation's only mobile renal dialysis program. Our capital outlay has been considerable, but not ill-advised. Because in every case, and for every project, we acted within existing State and Federal rules or guidelines and with full approval of all required planning agencies. In short, we have become what we are today - a truly unique Referral Center - with

your full encouragement and approval. And we believe that 300,000 residents of northern Michigan are better off because they no longer have to travel more than 180 miles to an urban area for specialty care.

These projects we referred to did not, as you might expect, come easily or inexpensively. Since 1977, over 50 million dollars has been expended on capital, and there remains some $26.6 million in bond indebtedness due in the year 2007. Our current annual capital costs amount to 12.0% of a 43 million dollar operating budget. (Details are provided on page 13 of the analysis given to you with our testimony). Clearly, the HHS/OMB Proposal is unacceptable, as it is applied retrospectively and is based on a national average capital cost of 6.9% that is almost half of our current level. The loss of millions of dollars to our hospital would be catastrophic, as 51% of our patients are Medicare sponsored.

These losses will make it virtually impossible for our hospital to keep pace with medical technology or make the necessary facilities changes that improve medical outcomes and increase cost efficiency. Restricting our ability to generate sufficient revenue to maintain our level of patient care will ultimately mean a decline in services available and, even more serious, a decline in the quality of services provided. The HHS/OMB Plan will punish the most modern, well-equipped hospitals in our country and those, like NMH, which serve a proportionately greater share of the Medicare population with "high-tech" care and services.

We believe that in order to implement an equitable, effective capital cost plan, the following should be considered:

1. We believe that Congress must get involved in the ultimate solution to the capital costs problem because failure to do so will relegate that responsibility to regulatory agencies.
2. There should be a "grandfathering" of capital expenditures made prior to the 1983 enactment of PPS.
3. A percentage add-on to hospital DRG payments should be implemented for capital expenditures made after the effective date of PPS reimbursement.

We believe that these actions will create a more equitable plan and one which will allow the industry to adjust to the new rules without being unduly penalized for abiding by the rules existent prior to PPS.

We have played by your rules and are clearly willing to do so in the future. But we cannot and should not be expected to change midstep and begin to march to the beat of a different drummer. We are asking for time and recognition of past, approved action. We believe that Northern Michigan Hospitals and our entire industry will then be able to adjust to a percentage add-on for capital costs.

Thank you.

CAPITAL COST ADD-ON:
HISTORY AND IMPACT ANALYSIS
FEBRUARY 4, 1986

I. Executive Summary

The issue of a capital cost add-on to the Medicare Prospective Payment System (PPS) is not new, having had its birth at the time of PPS legislation enactment in 1983. At that time, it was made clear to the department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and the healthcare industry as a whole that Congress was only allowing a temporary reprieve, or pass-through, of capital costs.

The Congressionally mandated time deadline has come and gone, and we are faced with HHS & OMB recommendations which, if allowed to pass with the Administration's 1987 Budget, will be devastating to Northern Michigan Hospitals, Inc. and others like it throughout the country.

The HHS recommendations released in December of 1985 were sufficiently stringent so as to be very detrimental to our future, yet these recommendations have become even more restrictive after review and revision by OMB. The resulting policy will bring more harm to our facility than the "regional referral hospital" issue faced in 1984 when the Health Care Financing Administration was compelled to allow exception for hospitals, like Northern Michigan Hospitals, Inc., with unique, referral situations in rural areas. This is especially true when one considers that a key determinant of a hospital's ability to offer top quality care is its ability to generate sufficient capital to make necessary facilities renovation and technological updates that improve medical outcomes and increase cost efficiency.

The question is not whether or not a capital costs add-on is appropriate or needed, but rather how such a program can be fairly implemented. The following document reviews the history of the capital costs issue, outlines current recommendations and our own history at Northern Michigan Hospitals, Inc. Further, it details the potential impact of the capital costs plans on our hospital and outlines recommendations to consider for amendment to proposed plans.

Complexity and Fairness

In addition, we believe that the issue is so complex that it would be irresponsible if Congress were not allowed to become involved in it's ultimate solution. There is too much room for error and an unfair implementation as the plan now stands. Some hospitals, like our own,

with relatively high mean ratios of capital to operating costs, will suffer proportionately more than those hospitals with low ratios, which would, in fact, receive a windfall from the HHS plan. It is our contention that some of the best hospitals in the country will fall into the former category. Clearly, if the plan cannot be implemented fairly, it should not be implemented at all.

Referral Center Recognition

We believe that Congress and the HHS must, once again, consider exceptional hospitals in their plans. At the time of implementation of the Prospective Payment System, HCFA recognized unique hospitals in rural settings. Northern Michigan Hospitals was among the first five in the nation to be recognized as a regional referral center. It seems only logical that a similar exception be considered in the capital cost add-on plan. Referral centers, by their very definition, will be more capital-intensive and technologically advanced. Therefore, they suffer a greater share of the impact of the capital cost add-on.

Phase-In

The seven year and subsequent five year phase-in terms recommended by HHS and OMB are too short and will virtually punish hospitals for past government approved expansions, acquisitions and improvements. It is an issue of changing rules without giving adequate time for the industry to adapt. A longer (11-15 year) phase-in, or "grandfathering" of pre-PPS expenditures with shorter (1-4 year) phase-in would give the industry an "adjustment" factor, yet still deliver mandated savings to the Medicare system.

Future Growth of the Industry

It is understood that it is not the responsibility of the Federal Government to insure the growth of any private industry. It follows, then, that it is also not their responsibility to insure detrimental inhibition of such growth. Yet, the proposed plan will do just that through increasingly restrictive annual payments for operating and now capital expenditures as well. It is a "double hit" that the industry cannot withstand.

We believe that our Hospital, and others in the country, has acted prudently and in the best interests of our patients in adding and improving facilities, technology and services throughout our history. With the full approval, and in many cases, open encouragement of our State government and local planning agency, we have undertaken programs which allow us to maintain special technology and services otherwise unavailable within 200 miles of our facility. We should not now be penalized for these past actions.

II. Historical Perspective On Capital Costs

The current debate on how to incorporate hospital capital costs into the DRG/Prospective Payment System (PPS) began with the enactment of PPS in 1983. The PPS legislation, while mandating prospective payment per case based on a patient's diagnosis, allowed for a temporary pass-through of capital related expenses such as depreciation, interest and others.

At that time, Congress required that HHS develop a plan to include capital costs in the PPS program. Clearly, it has been a concern of providers since that time, but more so now as we approach the new Congressional deadline of October 1, 1986. (The capital plan is to be included in the Administration's 1987 budget.) The issue has become a protracted battle between providers, HHS and OMB, with a variety of proposals having been submitted and discarded by all three groups.

The issue is extremely complex and, as indicated, fraught with a history of proposals and counter proposals. But there are clearly several overriding principles espoused by the Health Care Financing Administration which must be kept in mind when evaluating the existing plans or making recommendation for change of same. These (outlined by Dr. Carolyne Davis at the AHA meeting in January of 1984) are as follows:

"Given the complexities we face, we are still considering a broad range of approaches. But I can tell you that we will be guided by three overriding principles:

First, we do not want to make decisions on behalf of individual hospitals nor do we wish to guarantee individual hospitals a return on their investment. What we want is to get away from government planning. We want to set up appropriate economic incentives, then let hospital administrators decide how their hospital's surplus should be spent, accepting whatever risks ensue;

Secondly, we will give preference to methods that reduce your administrative and reporting load. The Medicare cost report is one of the more burdensome requirements the federal government has imposed and we want to lift as much of that burden as possible;

Finally, we will acknowledge that hospitals need a predictable capital payment and that a smooth transition period is needed to assure you of the continuity you need to meet your current obligations. Many highly leveraged hospitals with big capital costs would be hard pressed to meet current debt service obligations from their current operating margins, other revenue sources and any immediately foreseeable productivity gains."

These concepts are clearly acceptable to our hospital and, we believe, to the industry as a whole. The questions surface when these principles run head-on into the need for an equitable ("budget neutral") and easily managed policy ruling from HHS and OMB. Their history of rule making has been less than easy as the following historical synopsis indicates.

OMB, through their proposal submitted last February for the FY 1986 Budget, recommended that capital costs be folded into DRG rates via a declining capital add-on. The pass-through would have been eliminated, and hospitals would have received a declining percentage add on beginning with 6% per case in 1986, 5% in 1987, 4% in 1988 and so on. Opposed by HHS, the plan was dropped by OMB in exchange for a one year freeze of DRG rates.

In June of 1985, HHS completed its own preliminary recommendations which included a capital add-on phased in over a 5 year period during which time hospitals would move from a majority hospital - specific to a majority national rate and finally, the National rate in total. More importantly, the HHS plan recommended exclusion of a number of important capital items (eg., return on equity, revaluation of assets and interest on funded depreciation) from the capital base on which rates were figured. The result would have been major cuts in capital payments to hospitals. Again, an industry outcry caused HHS to modify the transition period, but it retained the exclusions. And still, no official HHS recommendation was issued. In September, it became clear that HHS and OMB were once more at a stand-off.

HHS maintained its desire to have a plan favoring an over-all capital add-on, but OMB opposed including fixed capital (buildings and beds), saying that Medicare should not continue to pay for an over-supply of beds. They favored the inclusion of equipment only.

Once again the Industry opposed the OMB plan and an appeal to HHS resulted in an agreement that HHS would propose a plan that would include a fixed and nonfixed capital add-on of about 6.9 percent. There would be a seven year transition period during which time hospitals would again move from rates more heavily weighted toward hospital - specific costs to those of a standard, national add-on. As hospitals moved closer to the national rate, the provision for inclusion of return on equity would be removed.

Objections from the industry to this revision included (1) the exclusion of return on equity, interest on funded depreciation and revaluation of assets from both the hospital-specific and national capital add-on portions of the rate, and (2) the use of 1984 as the capital base year. Together, these provisions would remove more than $1 billion from the capital base, and were clearly unacceptable to the Industry.

A compromise was reached when HHS agreed to include return on equity and interest on funded depreciation in the hospital - specific portion of capital payments, but not in the capital add-on portion - a move which would lead to their gradual phase-out. In addition, HHS agreed to base the hospital specific payments on the amount hospitals spent in each year of the phase-in period instead of basing all payments on FY1984.

The final, revised HHS report on capital costs was released in December of 1985 and indications are that the Administration will hold the report and incorporate its capital costs recommendation into the President's 1987 budget request. It is now known that OMB has made modification to the HHS report and that these modifications decrease the capital payment amounts recommended by HHS.

III. The HHS And OMB Recommendations

The HHS Report is grounds enough for concern by the Healthcare Industry, especially since it has been subject to further restriction by OMB prior to submission to the Administration.

The HHS Capital Cost Recommendations are:

Seven Year Transition As Follows:

YEAR	HOSPITAL-SPECIFIC	FEDERAL PORTION
1	95%	5%
2	90%	10%
3	80%	20%
4	65%	35%
5	50%	50%
6	30%	70%
7	10%	90%
8	--	100%

Hospital-specific capital costs would be defined using current Medicare reimbursement principles, i.e., depreciation, capital-related interest expense, lease/rental expense, applicable insurance and taxes and return on equity for proprietary providers; interest income on funded depreciation assets would not be offset. During the phase-in, the capital HSP in each year would be based upon each hospital's capital costs in that year.

The Federal portion would be calculated using costs in a base year; the base year is not defined in the report. The report only says that the base should be reasonably current, i.e., 1981 or later. The capital cost definition for the Federal portion is redefined in the report. Federal portion or national average capital costs are defined to exclude return on equity, and would require that funded depreciation interest income and interest income earned from restricted donations and unrestricted donated funds be offset against capital-related interest expense. HHS original intention to adjust capital costs for gains and losses on asset disposal and recapture of accelerated depreciation has been eliminated.

Budget neutrality will be achieved so that during the course of the 7-year transition period, by fiscal year, aggregate DRG-based payments for capital should be equivalent to estimates of what capital payments would have been using current Medicare reimbursement principles, except for the elimination of return on equity and the interest income offsets discussed above.

The Hospital Market Basket Index would have a proxy added to allow for updates of the Federal portion or national average capital payment rate.

The fiscal 1986 type charge-based DRG weights would be use as capital payments are incorporated into the PPS. If future DRG weight modifications (reclassification or recalibration) occur, HHS indicates that the modifications should appropriately reflect the incorporation of capital into PPS payment rates.

An all-inclusive payment rate concept (operating + capital costs) is recommended versus the use of a percentage add-on, e.g., Urban/Rural Standardized Operating Amount + Prospective Capital Standardized Payment Amount X DRG Weight = Hospital Payment.

The report strongly urges repeal of the S1122 and Federal Certificate-of-Need programs.

The recommendations would not apply to hospitals, units or services such as Part B currently exempt from the PPS.

It has been reported that OMB has revised the HHS recommendation once again, and has further restricted the capital cost payment to hospitals. Briefly, the OMB plan would call for a shorter phase-in period and other modifications as follows:

HOSPITAL REIMBURSEMENT

Capital Prospective Payment Policy

Proposal

Fold capital payments to hospitals into the Prospective payment diagnostic related group system according to the following methodology:

National Rate Calculation -- Take 1983 actual cost reports and remove capital payments for return on equity and interest offsets for funded depreciation out of the base. Update this base from 1983 to 1986 using the capital market basket. Update from 1986 to 1991 using the PPS update factor.

Hospital Specific Calculation -- Create a 1986 capital base for each hospital by subtracting return on equity and interest offsets for funded depreciation from the amount of capital shown on each hospital's 1986 cost report. In 1987, and subsequent years, pay each hospital the hospital specific portion (e.g. 80% of the base in 1987) based on the lower of: (1) the actual amount of allowable capital shown on each hospital's cost report (minus return on equity and interest offsets for funded deprecation), or; (2) the hospital's 1986 allowable capital base updated by the capital market basket. For the hospital specific portion, the capital market basket would be the actual capital market basket determined retrospectively.

Transition -- Phase in the national payment rates according to the following transition schedule: 1987 -- 80% hospital specific; 1988 -- 60% hospital specific; 1989 -- 40% hospital specific; 1990 -- 20% hospital specific; 1991 -- 0% hospital specific.

IV. Impact Of The HHS and OMB Recommendations

The major concern throughout the industry is well founded, and is most particularly acute in referral hospitals such as Northern Michigan Hospitals, Inc. where "high tech", intensive care has become our hallmark throughout the state and, in fact, the country.

Located in Petoskey, Michigan, Northern Michigan Hospitals began as the dream of a medical student determined to bring high quality, specialty health care to the residents of rural northern Michigan. During the 1930's that dream became a reality and since that time, our hospital has served with highly specialized, referral care a population that approaches 200,000 persons. It was and remains our mission to offer care to our patients on a par with any secondary and tertiary referral center.

Medical Staff Specialties

Within our 10 county service area, there are eight hospitals as shown on Map I. Primary and secondary physicians affiliated with these and other hospitals have developed a practical and mutually beneficial referral relationship with the 94 members of the NMH medical staff. Patients requiring specialty care have come to recognize Northern Michigan Hospitals as "the place to go when you're really ill" or when a serious emergency threatens life. Table I shows how service area residents answered during a recent community attitude survey when asked which hospital they preferred for various services.

Part of the attraction to NMH is our medical staff, 84% of whom are Board-certified medical specialists, and 90% of whom are members of the Burns Clinic Medical Center, P.C. In addition to the regular medical staff, we have ancillary staff specialties not routinely seen in community hospitals. These include a Ph.D. prepared Speech Pathologist, Audiologist, Biochemist, Psychologist and Radiation Physicist. Table II compares our staff composition to those of other hospitals in our service area and a large urban hospital located in southeastern Michigan (Detroit MSA).

It is apparent from these comparisons that our medical staff composition is clearly more like those of other national referral centers than those of rural community hospitals.

Facilities and Services

As is the case with medical staff specialties, the facilities and services provided at Northern Michigan Hospitals are specialty oriented and comparable to other referral centers. Table III compares our services to those of other hospitals in our service area.

Clearly, in order to support this level of services and medical staff specialties, NMH has had to expend millions of dollars to keep pace with medical technology and to provide services otherwise unavailable in our area. In 1981, we completed a $33 million dollar renovation and expansion project on which there remains a $26 million bond indebtedness due in 2007. This was followed by projects to purchase a CT Scanner, Radiation Therapy upgrading, Digital Subtraction Angiography and a $6 million project to consolidate all medical surgical beds at one campus. Our capital outlay has been considerable, but not ill-advised. All of our projects have been approved through the local and state planning agencies Certificate of Need process. Of the $20.3 million spent on capital since 1980, some $17.7 million has been financed from operations, $2.6 million from philanthropy.

It is evident that the HHS/OMB recommended capital cost add-on plan would be devastating to NMH and similarly configured institutions.

In addition to the facilities, services and medical staff at Northern Michigan Hospitals, our patients enhance our position as a unique referral institution. Over 60% of our patients are transferred from other hospitals, or are referred to us by physicians not holding privileges on our staff. These patients come surprising distances to receive highly technical, specialized care unavailable elsewhere in our service area. Map II shows that some 64% of our patients, on average, come from 25 or more miles away for treatment at NMH. This is another clear indication of our regional impact.

Our patients also tend to be more acute, that is, more severely ill when admitted to NMH. This is evidenced by our case mix index, which is among the top 5% in the state and the top 4% in the country. Of the 265 hospitals having a higher case mix index than NMH, only 8 are in rural areas. In Michigan, NMH is the only hospital of the 10 highest in terms of case mix that is located in a rural area.

Facilities, physicians and the kinds of patients treated here combine to make NMH a truly unique, regional referral center. And it is this very uniqueness which will hurt us most if the capital costs add-on plan is implemented in its current form.

Impact: The HHS Proposal

The following is an analysis of the potential impact on Northern Michigan Hospitals, assuming a 6.9% DRG add-on and using the NMH 1986 budget:

1986 Capital Cost	$ 5,126,000	1.5 Interest		
Medicare Utilization	.51	3.2 Depn	1.4 Bldg.	
		.4 Lease	1.8 Equip.	
Hospital Specific Medicare Capital Cost		$ 2,614,000	15.8%	
Medicare DRG Payments @ 4,150 Discharges	16,739,000			
National Capital Cost Add-on Percentage	.069			
Medicare Capital Cost Payment		1,155,000		
Projected Capital Cost Loss		$ 1,459,000		

The projected capital cost losses during the seven year phase-in are as follows:

Year	Excess Capital Cost		%		Projected Loss
1987	$1,459,000	X	.05	=	$ 73,000
1988	1,459,000	X	.10	=	146,000
1989	1,459,000	X	.20	=	292,000
1990	1,459,000	X	.35	=	511,000
1991	1,459,000	X	.50	=	729,000
1992	1,459,000	X	.70	=	1,021,000
1993	1,459,000	X	.90	=	1,313,000
1994	1,459,000	X	1.00	=	1,459,000
			Total		$ 5,544,000

IMPACT: THE OMB PROPOSAL

The following is an analysis of the potential impact on Northern Michigan Hospitals, assuming a 6.9% add-on and using the NMH 1986 budget:

Hospital Specific Portions

1986 Capital Cost	$ 5,126,000	
Medicare Utilization	.51	
Hospital Specific Medicare Capital Cost		$2,614,000
Less: Medicare Portion of Interest Income Earned on Funded Depreciation (290,000 x .51)		143,000
Adjusted Hospital Specific Medicare Capital Cost		$2,471,000

Federal Portion

Medicare DRG Payments @ 4,150 Discharges	$16,739,000	
National Capital Cost Add-on Percentage Less Allowances for Interest Earned on Funded Depreciation	6.9%	$1,155,000

Year				
1987	Hospital Specific Portion	2,471,000 x .80 =	1,977,000	
	National Portion	1,155,000 x .20 =	231,000	
	Medicare Reimbursement		2,208,000	
	Actual Cost of Capital		2,614,000	
	Loss for 1987			$ 406,000
1988	Hospital Specific Portion	2,471,000 x .60 =	1,483,000	
	National Portion	1,555,000 x .40 =	462,000	
	Medicare Reimbursement		1,945,000	
	Actual Cost of Capital		2,614,000	
	Loss for 1988			$ 669,000
1989	Hospital Specific Portion	2,471,000 x .40 =	988,000	
	National Portion	1,155,000 x .20 =	693,000	
	Medicare Reimbursement		1,681,000	
	Actual Cost of Capital		2,614,000	
	Loss for 1989			$ 933,000
1990	Hospital Specific Portion	2,471,000 x .20 =	494,000	
	National Portion	1,155,000 x .80 =	924,000	
	Medicare Reimbursement		1,418,000	
	Actual Cost of Capital		2,614,000	
	Loss for 1990			$1,196,000
1991	Hospital Specific Portion	2,471,000 x -0- = -0-		
	National Portion	1,155,000 x 1.00 =	1,155,000	
	Actual Cost of Capital		2,614,000	
	Loss for 1991			$1,459,000
	TOTAL			$4,663,000

There is no way that our hospital (and perhaps others like NMH) could withstand this kind of loss and still maintain the level of service and technology on which our patients have come to rely. To deny these people access to this level of care in our area would mean hardship in terms of travel and in terms of costs to the patient and ultimately the entire healthcare system.

V. Recommendation for Change

We recommend the following solution to the capital cost issue:

1. Congress should be involved in the ultimate solution.
2. A "grandfathering" of capital expenditures prior to the 1983 enactment of PPS should be provided.
3. A percentage add-on to hospital DRG payments could then be implemented for capital expenditures after the effective date of PPS reimbursement for each hospital.

The impact of this solution on Northern Michigan Hospitals is shown on page 18.

IMPACT: THE NORTHERN MICHIGAN HOSPITALS PROPOSAL

The following is an analysis of the potential impact on Northern Michigan Hospitals, assuming payment on long term debt, fixed equipment and plant on the current cost based system acquired prior to enactment of PPS (1983) and a percentage add-on for moveable equipment.

Hospital Specific Portions			
1986 Capital Cost	$ 5,126,000		
Less: Interest Expense	1,500,000		
Buildings and Fixed Equipment Acquired Prior to PPS 1983	1,200,000		
Total Capital Costs for Interest and Assets Acquired Prior to PPS 1983	2,700,000	$ 2,700,000	
Moveable Equipment and Buildings Acquired After PPS 1983	2,426,000		
Medicare Utilization	.51	.51	
Hospital Specific Medicare Capital Cost	1,237,000	1,317,000	$2,614,000
Federal Payment			
Medicare DRG Payments @ 4,150 Discharges		$16,739,000	
National Capital Cost Add-On Percentage		6.9%	
Payment for Moveable Equipment and Buildings acquired after PPS 1983			$1,155,000
Capital Costs for Assets Acquired Prior to PPS 1983			1,317,000
Total Medicare Payment			2,472,000
Projected Capital Loss			$ 142,000

VI. Glossary of Terms

Depreciation - An appropriate allowance on depreciable assets used to render services covered by the Medicare program.

Interest expense - Interest paid on current and long term capital indebtedness.

Lease and rental expense - Expenses incurred for the use of depreciable assets.

Fixed assets - Assets that cannot be easily moved, for example: building and attachments to building such as wiring, electrical fixtures, plumbing, elevators, heating systems, etc.

Moveable assets - Assets which are located in a relatively fixed location in a building, capable of being moved and cost sufficient to meet Medicare capitalization requirements.

Return on equity capital - The reasonable return allowed to proprietary providers on equity capital invested and used in providing patient care to Medicare beneficiaries.

Funded depreciation - The practice of placing funds in a segregated account for the acquisition of depreciable assets used in rendering patient care.

Medicare capital cost

- Net depreciation expense
- Taxes on land or depreciable assets used for patient care
- Leases and rentals
- Cost of Betterments and Improvements which extend the estimated useful life of an asset at least two years
- Cost of minor equipment that are capitalized rather than expensed
- Insurance on depreciable assets used for patient care
- Interest expense incurred on acquiring land or depreciable assets that are used for patient care
- A return on equity for proprietary providers
- The capital related costs of related organizations

Chairman STARK. Thank you very much and let me go through some numbers with you and see if you can help me in dealing with hospital accounting. In addition, I would like to raise just general policy questions.

The previous witness indicated that they had capital costs much lower than 18 percent prior to 1980 when they undertook a new building program. That might indicate in their case, that they were not adequately reserving for future expansion.

In other words, those were previous management errors in not providing enough to expand, and taking that into account in their pricing in the decade of the 1970's, and they just didn't have enough money. They had to expand. Normally if you were General Motors you might go out and borrow some money or sell capital stock, and in this case the Government agreed to pay for their institution.

I notice in your proposal—turn to page 13 for 1 minute and help me go through this. Anybody can jump on this. Your projected capital cost loss coincidentally happens to be within change of your building depreciation. You are showing $1,400,000 in annual depreciation that you ascribe to your building and that is just about how much you are coming out short.

Mr. RANEY. Yes.

Chairman STARK. From the standpoint of staying alive—let me go through this. I know you are anticipating a horrid suggestion on my part. Let me just play this out for a while. You could make it on a cash basis in round numbers, you just wouldn't have any depreciation or placement fund for your building.

Mr. WORDEN. Technically.

Chairman STARK. Buildings don't wear out, equipment does. There is a danger here. You are good guys, I have been told that by my colleagues, Mr. Frenzel, and others on the committee. But suppose you didn't take that $1,400,000 a year and in your case, Mr. Littler wasn't tending the store and keeping your nose to the grindstone, you did a lot of entertaining and bought a corporate jet and went to the Super Bowl and you didn't have the funds for rebuilding the building anyway. The Congress would have no control over that and you just might go out and spend it.

So there is a scenario that says maybe we take the money out of the Treasury to let you hold it in your local savings accounts, or maybe reinvest it in Government bonds. Should we hang on to it and wait for the funds to expire and then you come back to us and say, "We need another building?"

I don't know the answer to that, but in many cases, and this is my next question—do you solicit charitable contributions?

Mr. RANEY. Yes, we do.

Chairman STARK. Suppose you could raise $1,400,000 a year in contributions. That is what President Reagan is going to suggest. He is looking to the private sector to come in and fill some of these gaps and I would submit empirically that that is about the gap he is suggesting the good folks in your service area ought to contribute. That may be totally unrealistic to ask them to contribute.

I understand that you are doing the right business thing by accounting for your depreciation in that manner, but am I off base that you wouldn't run out of money on a cash basis and if you

could be assured of a continued charitable consideration or some replacement down the line, you could squeak through?

Mr. RANEY. In order for us to survive as the type of facility that we are, we cannot under existing prospective pricing legislation generate enough profit to maintain the type of facility we are. Therefore, we are forced to aggressively seek fundraising contributions and without the existing capital cost passthrough that is now—we now live under, it is going to be very difficult for us to maintain the type of facility which we are.

In the type of business which we are in, we can't generate the revenue in Michigan.

Chairman STARK. I understand that. I am suggesting listen to our problem as well as listening to yours. We don't use the same kind of accounting here that you do in Washington.

Mr. RANEY. I agree.

Chairman STARK. For a good reason. If we build a hospital for you, we expense it in the year we pay for it. You couldn't do that. So if we sell a national park next year, that will go against 1 year's budget and we will be out of pocket for the remaining years it takes to pay for it. You have to charge it off each year and rightly so.

All I am suggesting to you is that with the pressure we are under with budget constraints, maybe we are going to be forced to separate out the cash and noncash costs. And I don't mean to pick on you in that sense, but right here it happens to be your noncash costs that is your shortfall. Could I ask parenthetically in the year this illustration on page 13 was based on? What kind of charitable contributions did you raise in that same period, can you approximate that?

Mr. RANEY. 1986—we approximately get $200,000 to $250,000 in charitable contributions a year.

Chairman STARK. So you wouldn't cover that?

Mr. RANEY. Not at all.

Chairman STARK. Twenty percent at the most?

Mr. RANEY. Exactly.

Chairman STARK. I raise that as an issue, that if you had the cut in your proposal, in the short run the maximum you could cut to survive would be your noncash and preferably——

Mr. LITTLER. That is if we get the depreciation which we have to pay to bondholders, so this is not cash that we have available. Our debt service, payment on principal consumes the cash flow from depreciation.

Chairman STARK. So your $5,126,000 anticipates that depreciation, that is amortization?

Mr. LITTLER. Yes.

Chairman STARK. Your depreciation, is that parallel to your bond amortization so you can't do it?

Mr. WORDEN. Yes.

Mr. LITTLER. Another point that we might touch on, Dr. Helms mentioned that we have a spectrum of hospitals and capital costs, and he said that a large percentage falls in with this average group, but of course if you plan a national average to an average hospital, you should get a proper answer, but the trouble comes in in applying a national average to the opposite end of the spectrum

d there are a lot of hospitals on the bottom and Dr. Helms reed to that that are going to have a windfall out of it.

On the other hand, there are hospitals on the high technology d that will be penalized. It seems wrong to take money from the spitals that ought to continue and provide the service and give it hospitals that don't need it.

I think the solution of that would go a long way toward helping nd an answer to this problem. I am just a country boy and I am eminded of the story, applying those national averages, the fellow hat drowned in a river that on the average was 6 inches deep.

You get something like this, in our hospital you drown because e are on the high technology end of the scale.

Chairman STARK. It was indicated there would be some hospitals xempted, you are not one of them?

Mr. RANEY. No; we are not a sole community provider.

Chairman STARK. You heard discussion earlier about what would happen if we just changed these transition years. Would moving he transition years to 7 years solve your problem, or do you need djustments other than just a pure question of transition?

Maybe you haven't had a chance to study the proposal.

Mr. RANEY. It won't solve the problem. If you would move it to 2,007, we would be more than happy.

Chairman STARK. Do you have figures on a variety of transition periods?

Mr. RANEY. In our detailed analysis, we have covered 5 years and 7 years, assuming a 6.9 percent add-on.

Chairman STARK. On page 13, what are you using there as a transition?

Mr. WORDEN. Seven years.

Chairman STARK. So 5 years makes it worse?

Mr. WORDEN. That is right.

Chairman STARK. Ten years doesn't solve it either?

Mr. WORDEN. Ten years helps, but it still doesn't solve the problem.

Chairman STARK. I want to thank you very much for sharing this testimony, and I would like, if the staff is able as we get into this further and we have as the committee deliberates on alternatives and types of transition, I hope you will be good enough to crunch our numbers for us and tell us. We may not be able to solve all your problems, but we would like to, as we go along and try to work out a transition, see if we can accommodate all these who testify.

I hope we can call on you for more assistance in the future.

Mr. WORDEN. Please do. Thank you very much.

Chairman STARK. Our next witness is Mr. Mitchell B. Smith, executive director of the Humana Hospital-Sebastian, Sebastian, FL.

Welcome to the committee, Mr. Smith. Please proceed.

STATEMENT OF MITCHELL B. SMITH, EXECUTIVE DIRECTOR, HUMANA HOSPITAL-SEBASTIAN

Mr. SMITH. Mr. Chairman, thank you.

We appreciate the opportunity to be here with you. I am Mitchell B. Smith. We operate a hospital in Sebastian, FL, on the east

pages tightly bound

central coast of Florida. We are in a rural area. We are the only hospital within a 15-mile radius.

About 60 percent of our patients are Medicare beneficiaries. In the immediate Sebastian area, within a 9-mile radius, about 40 to 50 percent of the residents are elderly citizens.

Shortly after the hospital opened in 1974, we had to close the doors pending bankruptcy. In, from 1975 to 1978, Humana, Inc. acquired the hospital and the management company.

During the early years, the hospital operated on the fringe of bankruptcy. There was no cash flow, no savings, no borrowing power. We really survived on a week-to-week basis barely being able to meet the payroll.

The building and grounds were in very poor condition and the daily focus was on basic survival. We really faced a very bleak situation.

The residents of the community were mostly elderly and there was no other place for them to go because the other hospitals 15 to 25 miles away were 100 percent occupied.

Humana, upon acquisition, immediately began upgrading the systems and the hospital facilities.

We added a new emergency room at much great expense because providing that service is very expensive and we had a very low volume. It was a loser financially.

We also immediately began improving the maintenance and the safety of our building and grounds. We had a leaky roof. I remember that well. It cost $140,000.

Beginning in 1981 and 1982, our community started growing at a rather explosive rate of 18 percent and primarily again we were in the senior citizen category.

We applied for and received approval for a $6 million expansion. We included maternity and we included a new emergency room as well as many other services.

We have also purchased considerable other equipment such as a CAT scanner, digital radiography, ICU monitoring systems. We were really trying to bring the hospital up to par with others.

We implemented an out-patient surgery program to lower the cost of surgery.

I can honestly say that had it not been for Medicare, I don't believe that we would have had the ability to provide these services for this community. The residents would have been denied adequate and proper care.

We not only purchased needed equipment and services, we also corrected chronic overutilization of acute hospital care services and we promptly implemented our quality assurance program to assure those residents that they were getting good care.

We now have a top-notch hospital with excellent personnel. We have state-of-the-art equipment and we are serving this elderly community. The hospital is now profitable, but the profit is modest.

Our after-tax margin for the last 6 years has averaged 3.3 percent.

Mr. Chairman, the major problem confronting the hospital now is continued growth and our ability to serve the residents of our community. We have had a census increase each year.

We are unlike many hospitals. In 1979, our average daily patient census was about 48. Today we are running about 82. We do need to further expand the hospital at this time. One of the reasons, of course, is that the hospital has only 676 square feet per occupied bed.

When we build a new hospital, that figure goes to about a thousand. We need to upgrade our surgery. We have outgrown that and there are problems in operating the surgical unit. If we do not receive favorable capital payments from Medicare I don't believe we can expand and keep up with community growth.

We have the fourth highest housing cost in the State. However, the county is considered a rural area for Medicare reimbursement purposes.

Interestingly, the hospital is located 1 mile from the Brevard County line and our costs are the same as for hospitals in that county. Yet, we estimate that we are getting $300 to $500 per case less than the hospitals in Brevard.

In summary, I would like to state that our hospitals started with a bleak picture. Humana improved the quality of care. We reduced the cost to Medicare by reducing overutilization and developed a hospital that better serves our community. Without adequate payment for Medicare, the residents of our growing community would have no ready access to hospital care and without continuation of fair payment recognizing our capital needs, residents of the community will not enjoy the high quality of health care we endeavor to deliver.

You have asked questions of some of the others how this would impact us. About 22 percent of our Medicare payments are for capital, so it would greatly impact us. It is my opinion that if the administration's proposal were to go through we would have very serious problems and probably go back to where we were in 1978 and that is bankruptcy.

Mr. Chairman, I want to thank you for this time.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

MITCHELL B. SMITH

EXECUTIVE DIRECTOR

HUMANA HOSPITAL - SEBASTIAN

SEBASTIAN, FLORIDA

I am Mitchell B. Smith, executive director of Humana Hospital-Sebastian, owned by Humana, Inc. of Louisville, Kentucky. Humana Inc., a publicly held hospital management company, owns and operates 87 hospitals here and abroad in 20 states and three foreign countries. We are a member of the Federation of American Health Systems.

Humana Hospital Sebastian formerly named Sebastian River Medical Center was opened in 1974 as a small 103 bed community non-profit hospital. We are located between Vero Beach and Melbourne on the Central East Coast of Florida in Indian River County. We are the only hospital within a 15 mile radius. We serve a population of approximately 20,000 within a 9 mile radius. We are a semi-rural/suburban area originally a bedroom community of both Melbourne and Vero Beach. Approximately 60% of our patients are Medicare beneficiaries and we also have many tourists visiting our area. Approximately 22% of the Indian River County is aged 65 and over. The immediate Sebastian area within the 9 mile radius of our hospital has a much higher percentage of elderly - 40-50%. We are a mid-American community, with a family oriented, retired population and heavy seasonal fluctuation in population because of the migration of elderly and tourists from Northern States.

Shortly after the Sebastian River Medical Center opened as a non-profit institution it had to close its doors pending bankruptcy. Thereafter it operated under a management contract from 1975 to 1978 at which time Humana Inc. acquired the management company. During the acquisition, the non-profit hospital was converted to a Humana investor-owned hospital. During the

early years, the hospital operated on the brink of bankruptcy. When I took over as director of the hospital in 1978, there was no cash flow, no borrowing power, no surplus. We survived week to week just able to meet payroll. We could not pay the outstanding management company fees. The building and grounds were in very poor condition. The day to day focus was on basic survival. There was chronic overutilization. Most patients did not require acute care and should have been in a lower cost nursing home setting. We faced a very bleak situation. The residents of the community, mostly elderly, really had no other place to go since the other hospitals 15 and 25 miles away were 100% occupied. When Humana assumed the responsibility for the hospital, it was a nonmarketable commodity. No one else wanted it.

Humana upon acquisition immediately began upgrading the facility and systems, with a significant infusion of capital:

1. We implemented a full-time, 24 hour physician staffed Emergency Room as a service to the community. Although the Emergency Room experienced low utilization and was a revenue loser, we believed that the community needed the availability of this service and initiated it. Our emergency room still operates with a low volume of patients.

2. We immediately began improving the maintenance and safety of the building and grounds. We had a leaky roof, faulty air conditioning system, etc. and therefore made the necessary repairs and renovations.

3. Beginning in 1981 and 1982, our community started growing at an explosive rate of 18% per year (the County population as a whole grew at a rate of 6% per year), primarily, the senior citizen population increased. We applied for and received a Certificate of Need (CON) for a $6 million dollar expansion. We

included in our CON application, a Maternity Unit and a new Emergency Room. Previously, younger patients were having to drive 15 miles for these services. We have purchased considerable other equipment such as a CAT Scanner, Digital Radiography, Telemetry, ICU Monitoring Systems, Ultrasound and Laboratory Analyzer, etc. We implemented Outpatient Surgery to lower the cost of surgery. We initiated many new programs such as Hyperalimentation, Unit Dose and I.V. Addititive; all quality of care services that most hospitals offer. We also established a Chemical Dependency Program for alcoholics and substance abuse patients. Total capital investment has reached $9 million.

I can honestly say to you that had it not been for Medicare reimbursement, I do not believe that we would have had the ability to provide these services for this community. The residents would have been denied proper and adequate health care. We not only purchased needed equipment and services, we also corrected chronic overutilization of acute hospital care service. We promptly implemented our Quality Assurance Program. Today, our length of stay is in the normal range of other comparable hospitals. And, our utilization and quality review is in place, that is, all of our patients are acutely ill and need a hospital environment rather than receiving only a nursing home level of care.

As a business enterprise, our motives were more than humanitarian. However, I believe that the real beneficiaries of what Humana has done in this community have been the residents of this community. We have a top-notch hospital with excellent personnel that is serving an elderly community. The hospital is now profitable, but the profit is modest. Our after tax margin for the last six years has been 3.3%.

The major problem confronting continued growth of our hospital and the ability to serve our growing census of elderly

patients has to do with Medicare reimbursement. We have had a census increase each year. Our average daily census (ADC) increased from 48 patients in 1979 to 76 patients in 1985 and continues to grow. We need to further expand the hospital. We are applying for a certificate of need to upgrade our surgery facilities. We have outgrown our existing surgical department. If we do not receive favorable capital payments from Medicare we will not be able to expand and keep up with growth in our community.

Although we have the fourth highest housing cost in the State, Indian River County is considered a rural area for Medicare prospective payment DRG rate purposes, (only 75,000 population). Interestingly, and significantly enough, the hospital is located one mile from the Brevard County line, a metropolitan district, with the Brevard Hospitals, eligible for the much higher urban DRG payment rate. Our costs are the same as these neighboring hospitals but because of our location we get less reimbursement under the Medicare prospective payment system, more than $500 per case less than hospitals in the adjacent county. Our lower wage index exacerbates the problem. We face the same problem as other "rural" communities bordering a metropolitan area and incurring similar costs for supplies and labor, but not receiving the higher urban rate.

In summary, our hospital started out with a very bleak picture. My company, Humana, improved the quality of care, reduced the costs to Medicare by reducing over-utilization, and converted this hospital to a full service, quality hospital that better serves our community. Clearly, without adequate payment from Medicare, the residents of our growing community would not have ready access to hospital care and without continuation of fair payment recognizing our capital needs, the residents of our community, present and future, will not enjoy the high quality of health care we endeavor to deliver.

Chairman STARK. Mr. Smith, you are still 103 beds?

Mr. SMITH. We are 133 beds now. We started out at 103 beds, now we are 133 beds.

Chairman STARK. So your percentage of occupancy hasn't gone up really very much?

Mr. SMITH. It has. I gave you the average daily census. It started at 48 and now we are 82, so that is almost 100 percent growth. In the first of 1984, we opened the additional 30 beds. A part of those beds were for substance abuse and maternity.

Chairman STARK. I guess it would help us to know specifically, and you might like to submit that to the committee separately, just how the proposed Federal program will affect your hospital and will you be getting more in overall income from Medicare than you are getting now? Will you be getting less, and do you know how it would be if the transition were extended to 7 years?

You have heard those comments. That would be very useful for us to now.

Mr. SMITH. I know some of the figures. I think I mentioned 22 percent. Under Medicare reimbursement, we are receiving a total of $6,971,421; 22 percent of that is our capital cost. Now that is quite a bit higher than the 6 percent and 7 percent proposed by the administration. That means we would no longer receive $1,975,000.

Now, for the last year, I didn't make that much profit and also if we lose the return on equity of $454,000. I would be back into the bankrupt days of 1978. I don't have enough money to operate. The 7 years would help, but 10 years would help also, but 20 years would be a lot better.

Chairman STARK. Let me just see if I can add that. You had a $6 million expansion. Did that include all this other equipment and things that you list in your testimony on page 3? In other words, what was the total amount you spent those couple of years?

Mr. SMITH. Yes, sir; that was one major project. It included part of the CAT scan, some of the emergency room and in the 8 years that we have been there, it also—the figure in the testimony is the total capital expenditure that we have incurred.

Chairman STARK. So you have incurred $9 million in expenditures in 8 years.

Mr. SMITH. Yes, sir.

Mr. STARK. And you are recapturing that at the rate of $2,430,000 a year?

Mr. SMITH. Where are you getting the $2 million?

Chairman STARK. $1,975,000 and $454,000 on return on equity, so you are geting a capital reimbursement of about two-sixths on a $9 million——

Mr. SMITH. No, sir; I don't believe so. This year the return on equity is about $454,000. This is the first year that we will get any substantial return on equity.

Chairman STARK. And it is also $1,975,000 capital reimbursement, which totals about $2,430,000 and the investment was $9 million.

Mr. SMITH. That is part of the investment. The total investment is worth about $12 million. We owe in long-term debt roughly $2,013,000 plus $4,090,000 in debt incurred by Humana Corporate but allocated by Medicare to Humana Hospital Sebastian.

Chairman STARK. Well, if we could have some more detailed figures on that, I think it would be very helpful to the subcommittee.

Mr. SMITH. We will be glad to provide those to you.

Chairman STARK. Thank you very much.

[The information follows:]

Hospitals in multihospital systems typically use two accounting systems—one for their own internal control purposes and one to comply with Medicare cost reporting requirements. Humana corporate can raise debt and equity capital less expensively than any one of its hospitals. Consequently, debt and equity are obtained at the corporate level with allocations to individual hospitals made via the equity accounts. Thus, financial statements at the hospital level often will show large equity amounts even though the hospital's "equity" is in effect an intercompany note payable and much of the individual hospital's "equity" has been financed by corporate debt.

Medicare requires that corporate debt and equity be allocated to individual hospitals. Medicare audits typically result in disallowances of some assets and liabilities not deemed related to Medicare patient care. Debt is allocated according to the ratio of each hospital's intercompany note payable to the total corporate intercompany notes payable. Corporate equity is allocated by patient days.

As shown by the exhibit comparing the Sebastian Hospital financial statement with the Medicare statement, the equity account shrinks dramatically when the Medicare allocation procedures are followed.

HUMANA HOSPITAL SEBASTIAN

Comparison of hospital financial statement with statement used by Medicare for capital payment purposes—month of August 1985

	Thousands
Financial statement:	
Debt—Hospital Specific	$2,013
Equity:	
Retained Earnings	2,417
Inter-company Note Payable (Amount Humana Inc. has contributed to Humana Hospital-Sebastian)	,647
Total	10,064
Medicare statement for capital payment purposes:	
Debt:	
Hospital specific	2,013
Net home office debt allocation	4,090
Total	6,103
Equity:	
Beginning	10,064
(less) Medicare adjustments as result of audit	(1,475)
(less) Net home office debt allocation	(4,090)
Total	4,499

Reconciliation:

Financial Statement Debt + Equity = $12,077,000.

Medicare Debt ($6,103,000) + Medicare Equity ($4,499,000) + Medicare Disallowances ($1,475,000) = $12,077,000

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you very much, Mr. Chairman.

Mr. Smith, in what year was your certificate of need that you mention on page 3 received?

Mr. SMITH. 1983—I think it was March—1982, I'm sorry. March 1982. We began the process in 1981. We opened the facilities the end of 1983, the first of 1984.

Mr. GRADISON. I am not familiar with the way in which financing is done by your parent company, Humana. Is the borrowing done for each specific hospital, a separate borrowing or is this a joint-and-several borrowing by the parent corporation and then they channel the resources to an individual institution?

Mr. SMITH. As I understand, it is done both ways depending on the individual situation. I might mention that in our certificate of need application we generally would indicate how much money we are going to borrow and how much equity we are going to use. In that particular time, I believe it was 71 percent, 29 percent or something like that, pretty close to that figure.

Mr. GRADISON. What is the nature of your debt? Is it guaranteed by Humana or is the security the resources of your individual institution?

Mr. SMITH. Well, I am not sure that I fully understand——

Mr. GRADISON. How much debt do you have outstanding for your institution?

Mr. SMITH. $6,103,000 long-term debt and Medicare allowable equity of $4,499,000.

Mr. GRADISON. Who owes the $6,103,000?

Mr. SMITH. Humana, Inc. owes the long-term debt.

Mr. GRADISON. The parent company?

Mr. SMITH. Yes.

Mr. GRADISON. I am not advocating that we underpay you, but I don't understand how you would get forced into bankruptcy if you don't get enough money. Why can't Humana pick it up?

Mr. SMITH. That is an interesting point. The company doesn't feel it is fair for one community to provide resources to another community. This hospital is expected to pay its own way. Humana obviously gets its revenues from various communities of hospital patients and it is a basic policy that we be self-supporting.

However, when you are building a new hospital, that is about the only time Humana will help a new hospital get established.

Mr. GRADISON. So they would be willing to jeopardize their own credit rating? If their name is on it and you don't have the money, they have to pay regardless of their policy. I don't understand your point about bankruptcy. I understand your point about getting an adequate payment. Presumably they have some institutions higher than 6 percent and some less than 6 percent. Are you saying they won't move money from the ones with less than 6 percent to the ones with more than 6 percent in order to balance the load because they don't move it from community to community?

Mr. SMITH. You are asking questions that are probably getting more into Humana policy and we probably need to get back to you with specifics.

Mr. GRADISON. Would you do that, because I don't understand your basic policy. I understand the numbers clear enough, but I don't understand your basic point that an underpayment from Medicare in your case would cause those bonds to go into default. That is the specific question I wish you would send us more information on, if you would please.

Mr. SMITH. I will be glad to.

[The information follows:]

Technically, an underpayment from Medicare to Humana Hospital Sebastian would not cause bonds secured by the corporation to go into default. But, if Medicare payments were reduced to the point where it was impossible for my hospital to earn a fair return or operate in the black, Humana would face all bad choices: require other communities to subsidize Sebastian, close the hospital, or convert it to another use.

Chairman STARK. I wanted to also see if I understand this. There is about $6,103,000 of debt outstanding.

Mr. SMITH. Yes, sir. That is long-term debt.

Chairman STARK. Long-term debt, and ignoring the return for equity for a minute, you are getting $1,975,000, almost $2 million that ought to be just about paid off in 3 years or so, shouldn't it? If you could afford to apply the capital reimbursement, you are getting almost 90 percent of that back. Am I correct?

Mr. SMITH. I am not sure of the long-term debt. If it is 10 years or 20 years or what that is, I didn't bring that figure with me.

Chairman STARK. That is the total debt, that is the annual payment?

Mr. SMITH. Yes, sir. However, now, the other equity could be funded through various short-term instruments through Humana, Inc. They could have short-term liabilities, and probably do.

Chairman STARK. You indicated that the equity Humana has is $10,600,000 and the long-term debt is $6,103,000. That sort of totals up the investment.

Mr. SMITH. Yes, sir.

Chairman STARK. Did that change? Does that adjust from time to time?

Mr. SMITH. There is no rule of thumb. That is just the way it happens in this particular point in financing for this hospital. I think the major point again is as I hear you are saying, why can't Humana, Inc., divvy up——

Chairman STARK. No, Mr. Gradison said that. It is not a bad idea, but I just want to give credit where credit is due.

Mr. SMITH. That would be nice in my position, but unfortunately we have to stand alone and I think that is a good philosophy.

Chairman STARK. Let me ask you this. On your direct costs of operating as I understand it, you are getting about $5 million in Medicare contributions exclusive of capital.

Mr. SMITH. Yes, sir.

Chairman STARK. What was, again excluding capital, your gross income last year?

Mr. SMITH. Last year, $1,900,000.

Chairman STARK. No, I mean your revenue.

Mr. SMITH. About $21 million, $22 million, somewhere in that ballpark.

Chairman STARK. So Medicare was only paying 25 percent?

Mr. SMITH. Yes, sir. Well, wait a minute now. We write off a big portion of that to contractual because Medicare will not pick up their fair share. There is a very strong cross subsidy program going on in Florida because—I am sure you have heard that before and we are a victim of the cross subsidization. We are going after the other commercial carriers to pay for what Medicare does not pay.

One of the problems is we have 60 percent Medicare patients. That gives us a distorted picture financially because of that problem. I am from South Carolina originally, hospitals there are getting 20 or 30 percent Medicare.

Chairman STARK. Thank you very much.

Mr. Smith, to the extent that you could calculate for us what will happen under this proposal that the administration submitted

and send it to the committee, that would be very useful in our deliberation.

[Nothing further was received.]

Chairman STARK. We appreciate very much your taking the time to be with us. It is my understanding that Dr. Abercrombie was unable to be here.

Chairman STARK. Our next witness will be Mr. Dan Wood, who is vice president and treasurer of the Good Samaritan Hospital in Cincinnati.

Mr. GRADISON. Mr. Chairman, I not only would like to welcome Dan Wood, but thank you personally for making it possible for him to appear as a witness. I had an opportunity at the invitation of the Catholic Hospital Association to spend an hour or so with them recently to go over a computer program which they had developed to assist their own hospitals in measuring the impact of some of these alternative reimbursements for capital plans. The specific figures that we saw that morning were put together around the figures of Good Samaritan, but I believe they are available for other hospitals in the group as well.

I can only say, Mr. Chairman, that I came away with two conclusions. One is that there are pretty scary scenarios out there in terms of the ability of some of these institutions to meet their obligations under the HHS plan; and second, that I think the witnesses that we are increasingly hearing from, including the next one, are just the tip of the iceberg.

It is my impression that there are lots of other institutions out there and that this is just a handful with special problems.

Thank you, Mr. Chairman. I look forward to Mr. Wood's testimony.

Chairman STARK. Mr. Wood, we are happy to have you here. I was pleased to be totally confused by your detailed printout, but Mr. Gradison assures me that it is all bad news and it is up to us to correct it. I know he has had the opportunity to visit your hospital. I look forward to your summarizing your testimony in any way that you care to. I think you have also heard the testimony of the administration and the American Hospital Association and the questions of the committee today and any suggestions about the direction that we might take in finding a compromise that will satisfy all the pressures on us would be greatly appreciated.

With that, you may proceed in any manner you desire.

STATEMENT OF DANIEL G. WOOD, VICE PRESIDENT AND TREASURER, GOOD SAMARITAN HOSPITAL, CINCINNATI, OH

Mr. WOOD. Thank you, Mr. Chairman and subcommittee members. It is my pleasure to appear before you. I am representing Good Samaritan Hospital, which is a Catholic teaching hospital of 710 beds in Cincinnati, OH. The hospital was originally founded in 1852. The hospital began a major replacement program in 1979. The plan was approved by local and State planning agencies and the approval date was April 1981. All the buildings being replaced were built in 1915 and 1927. It is not an expansion program and in some instances a contraction of the sites.

The hospital used good financial planning and used tax-exempt short-term financing in the period of 1981 through 1983 because the long-term tax-exempt rates were at an all-time high. The hospital then refinanced this short-term money and saved approximately $13 million in capitalized interest.

I mention this because I believe it demonstrates that the hospital did not proceed irregardless of the cost of money, but used prudent management even though it was cost-reimbursed.

Since our initial planning, a number of items have changed.

On April 20, 1983, the PPS system was announced and the hospital came under PPS July 1, 1984. The proposed change from cost passthrough was also announced on April 20, 1983. The proposed fold-in of capital to the DRG prospective payment system places another change on the hospital which was not contemplated in its planning.

All of our planning in the project was obligated prior to the date of April 20, 1983, and therefore, we believe we should be held harmless on this new PPS fold-in.

Good Samaritan Hospital has attempted to model what it thinks is the administration's program. The evaluation is made difficult because the details have not officially been made public.

One, we really need to know what the value of a national rate is; and two, how do you determine the specific portion of the hospital rate during the phase-in.

To do our analysis, we were forced to make a number of assumptions, some of which were provided by the Catholic Health Association and others by the California Hospital Association.

We also made assumptions as to the case mix, the number of Medicare admissions and the medical education for the upcoming years.

We ran our assumptions on two scenarios. One, that the market basket approach which we were promised under the prospective payment system would be honored and we used as those rates the hospital insurance fund that was projected in April 1985. The other scenario is using the Gramm-Rudman, that is to state that we do not expect to see future PPS increases.

The major problem that we see is that Congress and the administration is going to have to give us numbers as far as the annual adjustment update. These new rates will not only affect those in operations, but a capital fold-in would also affect the capital side of the equation.

I have prepared some schedules which are run under the Gramm-Rudman and also under the market-basket approach.

Column No. 108 of schedule 8 shows under the Gramm-Rudman that I sustain an annual operating loss each year. This is both from the prospective payment and the capital fold-in. Under the market basket approach, I also sustain a loss.

What this states is that I am not able to take a shortfall on the capital side and make it up with the payments from the PPS side. It is inevitable that I will not be able to make these payments.

Schedule 5 that I prepared takes current obligated capital. These are bonds which are outstanding and there is principal and interest due on these.

Column 54 shows that there is insufficient payments from the Medicare program to pay interest and principal. This is true under the market basket and Gramm-Rudman approach, both.

Who else will be hurt besides the patient and hospital industry? The individuals who purchased the hospital bonds will not be paid their interest and principal. The bonds are held mainly by individuals or individuals as a part of a bond fund.

In conclusion, Good Samaritan Hospital, we believe, is an efficient facility that has made sound business decisions regarding its capital only to find it will be severely penalized if the administration's budget prevails.

We believe the capital proposals surfaced thus far included in the administration's budget are unacceptable. Arriving at a capital payment mechanism that is fair and equitable will be far more difficult than all of us originally anticipated and that the impact of Gramm-Rudman-Hollings will make it doubly difficult to arrive at a fair and equitable payment.

The Congress should preclude the administration from proceeding to implement its capital proposal by regulation.

Congress also should direct either HCFA or HHS to perform through its fiscal intermediary a survey of all hospitals with respect to its capital obligations that have been made up to a date certain, maybe October 1, 1986. This data should be used as a framework against which the impact of the Medicare capital proposals are evaluated.

This survey would need to be separately funded because I believe the intermediaries are also suffering from Gramm-Rudman.

We would also hope that as the debate over capital continues and that more becomes known about the administration's capital proposals, that this committee knows more about how it may wish to configure its capital proposals and we would be most happy to provide additional input concerning this proposal or any others.

Mr. Chairman, I thank you for the opportunity to appear before you.

[The prepared statement follows:]

STATEMENT
of the
GOOD SAMARITAN HOSPITAL
CINCINNATI, OHIO
by
Daniel G. Wood
Vice President/Treasurer
Good Samaritan Hospital

I am appearing on behalf of the Good Samaritan Hospital and as a member of the Catholic Health Association.

The Good Samaritan Hospital of Cincinnati, Ohio, is a 710-bed tertiary teaching facility founded in 1952.

The Hospital began its planning for the replacement of a major portion of its facility in 1979. This plan was approved by the local and state planning agencies in April 1981. The areas being replaced were built in 1915 and 1927.

The Hospital used good financial planning and thus used short term, tax-exempt financing to span the period of 1981-1983 where long term, tax-exempt interest rates were at an all-time high. This strategy saved approximately $13 million in capitalized interest during construction. The Hospital refinanced with long term tax-exempt bonds in June 1984.

The above is mentioned because I believe it demonstrates that the Hospital did not proceed irregardless of the cost of money but used prudent management even though it was to be cost reimbursed.

Since our initial planning, a number of items have changed.

The PPS was announced April 20, 1983 and became effective at Good Samaritan Hospital on July 1, 1984. The proposed change from cost pass through was also announced on April 20, 1983. The proposed fold-in of capital to the DRG prospective payment system places another change on the Hospital which was not contemplated in its planning. It is our belief that all projects that were obligated prior to April 20, 1983 should be held harmless.

Good Samaritan Hospital has attempted to model the Administration's capital proposal and evaluate its impact on our hospital. This effort is made somewhat difficult because the Administration has come forward with so few details with respect to its capital proposal. At this juncture, the only official Administration pronouncement with respect to the Administration's capital proposal have been made as part of the President's proposed budget. In those and accompanying

documents, the only details of the capital proposal that have been made public thus far are:

- The amount of savings the Administration hopes to achieve by implementing a capital payment mechanism.
- The four-year transition period.
- The capital payment mechanism will be a flat dollar add-on to the non-labor portion of the PPS rate.

Details that have not yet been made public but must be known before the Administration's proposal can be adequately evaluated include:

- The dollar figure that will be used as the flat dollar add-on to the non-labor portion of the PPS rate in FY '87; and the specifics of the formula that will be used to derive that dollar amount.
- The specifics as to how the hospital-specific portion to be used during the transition period will be calculated.
- An estimate as to by how much the PPS rate will be increased on an annual basis.

In modeling the Administration's proposal Good Samaritan used a methodology supplied by the Catholic Health Association (CHA). CHA's methodology focuses solely on Medicare revenues and Medicare costs that are associated with services covered by Medicare's prospective payment system (PPS). We also used some assumptions supplied by CHA as substitute variables for the details missing from the Administration's proposal. Those assumptions include:

- A figure of $258.79 as the flat dollar add-on for urban hospitals in federal FY '87. That number was derived by the California Hospital Association based on assumptions supplied to it by the Catholic Health Association.
- A hospital-specific portion (HSP) that is the hospital's actual capital cost for the year in question. And,
- two assumptions about the annual update of PPS rates. One assumption assumes that the PPS rates will be updated on an annual basis in accordance with the projections issued by the Trustees of the Hospital Insurance Trust Fund. The second assumption assumes that under Gramm/Rudman/Hollings, the net effect of increases in the PPS rate proposed by the

Administration's budget and the sequestering that is likely to take place will result in a zero rate of increase in PPS rates between now and FY '92.

In evaluating the Administration's proposal we ran the model under both the Gramm/Rudman and the market basket assumptions.

Other assumptions made by Good Samaritan Hospital include:

1. Case mix index of 1.27 will escalate to 1.30 over the next 20 years.
2. Medicare admissions decrease in next two years but then slowly begin to increase because of the demographics of Cincinnati, Ohio, and that people over age 65 are living longer.
3. The direct medical education payment has been frozen at the June 30, 1985 level and held constant.
4. The indirect medical education has been reduced from 11.59% to an 8% factor. This 8% factor was then held constant.
5. Outlier revenue was estimated to remain at the same proportion as it currently is.
6. The current capital costs were adjusted for the two excluded units which will continue to be reimbursed at cost.
7. Future estimated capital expenditures were taken from the Hospital's internal plan. It was assumed that internal sources would be used to fund the expenditures, thus no new interest and principal. (This assumption will not hold if the current depreciation is not able to be funded because of Medicare cutbacks.)

Results of GSH Evaluation

CHA's assumptions and Good Samaritan's assumptions were entered into CHA's modeling program in an attempt to evaluate the impact of the Administration's capital proposal under two scenarios regarding the rate at which the PPS rates would be updated each year to account for increases in hospital input prices.

I Gramm/Rudman/Hollings

II Market Basket

The attached computer printouts display the impact of the Administration's proposal in the context of Good Samaritan's

- Current and obligated capital costs (Schedule 5)

- Current/obligated and Future capital costs (Schedule 7), and
- Total Medicare payments for operations and capital costs as compared to hospital and operating costs and capital costs for services covered by Medicare's PPS. (Schedule 8)

Under Gramm/Rudman

Schedule 5, Current and Obligated Capital Costs, Column #65, shows that the Medicare capital payment mechanism would be insufficient to allow Good Samaritan to cover its principal and interest obligations for its current capital obligations through the year 2001. The accumulated shortfall in 2001 is $6,318,493.

Schedule 7, Impact of Medicare Capital Payment Proposal on Old and New Capital, combines the capital costs that are currently obligated with Good Samaritan's future capital costs associated with needed equipment replacement. This calculation only includes new equipment costs and does not include renovation or replacement costs.

This schedule clearly demonstrates that the Medicare capital payment would be clearly insufficient to meet Good Samaritan's accounting costs for old and new capital. The crossover point where Medicare's capital payment meets or exceeds the hospital's capital costs is the year 2010 -- some 25 years into the future.

Schedule 8 really compares the hospital's Medicare revenue under PPS with the hospital's cost of furnishing services covered by PPS. Under Gramm/Rudman with no increase in PPS rates until FY '92, Good Samaritan can expect losses of such substantial magnitude they quickly become unsustainable. These losses are due for the most part to the effect Gramm/Rudman will have on the operating side of PPS.

Under Market Basket

When the PPS rates are updated by the value of the hospital market basket the effects of folding in capital into PPS are not nearly so devastating, but they are still unacceptable to Good Samaritan.

Schedule 5, Column #65 shows that the Medicare capital proposal would be insufficient on an annual basis to allow the hospital to meet its debt service requirements until 1996. At that point in time the accumulated shortfall is $1,372,196.

Schedule 7 indicates that even under a scenario in which PPS rates are increased each year by the market basket the Medicare capital

payment in any year would be insufficient to cover the Hospital's capital costs during that year until 2005. The accumulated shortfall would be $22,976,204.

Schedule 8 which compares Medicare PPS revenues to Medicare costs for services covered by PPS clearly indicates that even under a generous assumption about the annual rates of increase in PPS rates the revenue Good Samaritan receives from Medicare's PPS would be insufficient to cover its operating and capital costs.

Conclusion

In conclusion, Good Samaritan Hospital, Cincinnati, Ohio, is an efficient facility which has made sound business decisions regarding its capital expenditures only to find it will be severely penalized if the capital fold-in continues as outlined in the Administration's budget.

At this juncture, we at Good Samaritan believe that:

1. The capital proposals that have surfaced thus far, including the Administration's, are unacceptable.
2. Arriving at a capital payment mechanism that is fair and equitable will be more difficult than all of us originally anticipated; and that the impact of Gramm/Rudman/Hollings will make it doubly difficult to arrive at a fair and equitable Medicare capital payment methodology.
3. That Congress should act at its earliest opportunity to preclude the Administration from proceeding to implement its capital proposal by regulation.

We would also hope that as the debate over capital continues and more becomes known about the Administration's capital proposal, and this Committee knows more about how it may wish to configure a capital proposal, that it will provide another opportunity for us, Good Samaritan, as well as others, to evaluate those proposals and appear before you with our evaluations and comments.

Thank you, Mr. Chairman, for the opportunity to appear before you and the Committee today. This concludes my prepared remarks. I'll be happy to answer any questions.

14-Feb-86 CATHOLIC HEALTH ASSOCIATION of The UNITED STATES WorkSheet by FCC

SCHEDULE 5

SCHEDULE OF CURRENT AND OBLIGATED CAPITAL COST
SUMMARY OF IMPACT OF MEDICARE CAPITAL PAYMENT PROPOSAL ON OBLIGATED HOSPITAL CAPITAL

Line	HOSPITAL FISCAL YEAR END col 62	MEDICARE CAPITAL with PHASE IN: EVEN 5 Year col 63	MEDICARE CAPITAL PAYMENT VS HOSPITAL PRINCIPAL AND INTEREST PAYOUT: TOTAL PIO col 64	ANNUAL GAIN or LOSS col 65	ACCUM GAIN or LOSS col 66	MEDICARE CAPITAL PAYMENT VS HOSPITAL DEPRECIATION, INTEREST and OTHER: TOTAL DIO col 67	ANNUAL GAIN or LOSS col 68	ACCUM GAIN or LOSS col 69	******** VARIANCE ANNUAL GAIN or LOSS	******** VARIANCE ACCUM GAIN or LOSS
1										
2										
3	June 1986									
4	June 1987									
5	June 1988	4,227,475	4,322,852	(95,377)	(95,377)	4,836,544	(609,069)	(609,069)	-12.59%	-12.59%
6	June 1989	3,487,547	4,179,799	(692,252)	(787,629)	4,612,970	(1,125,423)	(1,734,492)	-24.40%	-18.36%
7	June 1990	2,912,271	2,823,552	88,719	(698,910)	4,569,233	(1,656,962)	(3,391,454)	-36.26%	-24.19%
8	June 1991	2,377,081	2,826,146	(449,057)	(1,147,966)	4,564,832	(2,187,741)	(5,579,194)	-47.93%	-30.02%
9	June 1992	1,897,712	2,825,503	(927,792)	(2,075,758)	4,442,804	(2,545,093)	(8,124,287)	-57.25%	-35.28%
10	June 1993	1,379,352	2,821,994	(842,642)	(2,918,400)	4,191,668	(2,212,316)	(10,336,603)	-52.78%	-37.98%
11	June 1994	2,073,733	2,819,665	(745,932)	(3,664,332)	4,041,003	(1,867,270)	(12,303,873)	-46.68%	-39.36%
12	June 1995	2,172,632	2,816,742	(644,110)	(4,308,442)	3,855,467	(1,682,835)	(13,986,708)	-43.65%	-39.83%
13	June 1996	2,283,736	2,895,564	(611,828)	(4,920,270)	3,773,112	(1,489,376)	(15,476,084)	-39.47%	-39.80%
14	June 1997	2,392,594	2,890,499	(497,905)	(5,418,175)	3,727,346	(1,334,752)	(16,810,836)	-35.81%	-39.45%
15	June 1998	2,495,475	2,888,022	(392,547)	(5,810,722)	3,672,095	(1,176,620)	(17,987,456)	-32.04%	-38.88%
16	June 1999	2,614,312	2,883,364	(269,053)	(6,079,775)	3,597,932	(983,621)	(18,971,077)	-27.34%	-38.03%
17	June 2000	2,722,792	2,877,458	(154,667)	(6,234,441)	3,512,456	(789,665)	(19,760,741)	-22.48%	-37.01%
18	June 2001	2,869,053	2,953,105	(84,052)	(6,318,493)	3,529,441	(660,388)	(20,421,129)	-18.71%	-35.87%
19	June 2002	2,999,796	2,946,728	53,068	(6,265,425)	3,429,507	(429,711)	(20,850,840)	-12.53%	-34.55%
20	June 2003	3,136,499	2,938,531	197,968	(6,067,458)	3,325,372	(188,874)	(21,039,714)	-5.68%	-33.04%
21	June 2004	3,279,340	2,929,399	349,941	(5,717,517)	3,234,870	44,470	(20,995,244)	1.37%	-31.38%
22	June 2005	3,418,685	2,921,502	497,183	(5,220,334)	1,994,010	1,424,675	(19,570,569)	71.45%	-28.40%
23	June 2006	3,560,504	2,910,417	650,087	(4,570,247)	2,456,331	1,104,173	(18,466,396)	44.95%	-25.88%
24	June 2007	3,708,195	2,900,832	807,363	(3,762,884)	2,199,456	1,508,739	(16,957,657)	68.60%	-23.05%
25	June 2008	3,861,878	2,887,275	974,603	(2,788,282)	1,928,610	1,933,268	(15,024,390)	100.24%	-19.90%
26	June 2009	4,039,022	2,867,342	1,171,680	(1,616,602)	1,766,247	2,272,775	(12,751,615)	128.68%	-16.50%
27	June 2010	4,188,410	2,849,865	1,338,545	(278,057)	1,583,868	2,604,442	(10,147,173)	164.43%	-12.87%
28	June 2011	4,343,403	2,830,485	1,512,918	1,234,861	1,383,686	2,959,717	(7,187,456)	213.90%	-8.86%
29	June 2012	4,504,119	2,741,200	1,762,919	2,997,780	1,164,165	3,339,954	(3,847,502)	286.90%	-4.73%
30	June 2013	4,670,794	2,788,153	1,882,641	4,880,421	905,721	3,765,073	(82,429)	415.70%	-0.10%

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SCHEDULE 7 - Part 2 of 2

>>> S U M M A R Y S C H E D U L E <<<
IMPACT OF MEDICARE CAPITAL PAYMENT PROPOSAL ON OLD and NEW CAPITAL

MEDICARE CAPITAL PAYMENT vs DEPRECIATION INTEREST EXPENSE

Line	HOSPITAL FISCAL YEAR END col 86b	TOTAL OLD DIO col 95	TOTAL NEW DIO col 96	TOTAL DIO col 97	ANNUAL GAIN or LOSS col 98	ACCUM GAIN or LOSS col 99	******** VARIANCE ANNUAL GAIN or LOSS	******** VARIANCE ACCUM GAIN or LOSS
1								
2								
3	June 1986							
4	June 1987							
5	June 1988	4,836,544	595,825	5,432,369	(1,204,894)	(1,204,894)	-22.18%	-22.18%
6	June 1989	4,812,970	730,077	5,343,047	(1,855,500)	(3,060,394)	-34.73%	-28.40%
7	June 1990	4,569,233	879,246	5,448,479	(2,536,208)	(5,596,602)	-46.55%	-34.50%
8	June 1991	4,564,832	1,051,901	5,616,733	(3,239,642)	(8,836,243)	-57.68%	-40.46%
9	June 1992	4,442,804	1,236,888	5,679,692	(3,781,981)	(12,618,224)	-66.59%	-45.85%
10	June 1993	4,191,668	1,390,844	5,582,512	(3,603,160)	(16,221,384)	-64.54%	-49.00%
11	June 1994	4,041,003	1,521,844	5,562,847	(3,489,114)	(19,710,498)	-62.72%	-50.98%
12	June 1995	3,855,467	1,553,254	5,408,721	(3,236,089)	(22,946,587)	-59.83%	-52.06%
13	June 1996	3,773,112	1,638,346	5,411,458	(3,127,722)	(26,074,309)	-57.80%	-52.89%
14	June 1997	3,727,346	1,711,734	5,439,080	(3,046,486)	(29,120,795)	-56.01%	-53.02%
15	June 1998	3,672,095	1,766,695	5,438,790	(2,943,315)	(32,064,110)	-54.12%	-53.12%
16	June 1999	3,597,932	1,811,979	5,409,911	(2,795,600)	(34,859,710)	-51.68%	-53.00%
17	June 2000	3,512,456	1,857,263	5,369,719	(2,646,928)	(37,506,637)	-49.29%	-52.72%
18	June 2001	3,529,441	1,907,988	5,437,429	(2,568,376)	(40,075,013)	-47.24%	-52.33%
19	June 2002	3,429,507	1,958,714	5,388,221	(2,388,425)	(42,463,438)	-44.33%	-51.80%
20	June 2003	3,325,372	1,890,169	5,215,541	(2,079,043)	(44,542,481)	-39.86%	-51.09%
21	June 2004	3,234,870	1,736,556	4,971,426	(1,692,086)	(46,234,567)	-34.04%	-50.17%
22	June 2005	1,994,010	1,871,433	3,865,443	(446,759)	(46,681,325)	-11.56%	-48.62%
23	June 2006	2,456,331	2,019,553	4,475,884	(915,380)	(47,596,705)	-20.45%	-47.36%
24	June 2007	2,199,456	2,164,459	4,363,915	(655,720)	(48,252,425)	-15.03%	-46.02%
25	June 2008	1,928,610	2,300,039	4,228,649	(366,772)	(48,619,197)	-8.67%	-44.57%
26	June 2009	1,766,247	2,432,962	4,199,209	(160,187)	(48,779,384)	-3.81%	-43.06%
27	June 2010	1,583,968	2,565,885	4,149,853	38,557	(48,740,827)	0.93%	-41.50%
28	June 2011	1,383,686	2,698,809	4,082,495	260,908	(48,479,919)	6.39%	-39.89%
29	June 2012	1,164,165	2,729,277	3,893,442	610,677	(47,869,242)	15.68%	-38.17%
30	June 2013	905,721	2,758,574	3,664,295	1,006,499	(46,862,743)	27.47%	-36.31%

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SCHEDULE 8 - Part 1 of 2

>>> S U M M A R Y S C H E D U L E <<<
TOTAL MEDICARE FPS PAYMENTS for OPERATING and CAPITAL COST
---> compared to <---
HOSPITALS OPERATING and CAPITAL COST for SERVICES COVERED by MEDICARES FPS

Line	HOSPITAL FISCAL YEAR END col 100a	NET TOTAL FPS REVENUE col 101	MEDICARE CAPITAL REVENUE col 102	TOTAL MEDICARE PAYMENTS col 103	HOSPITAL COST for SERVICES COVERED by FPS col 104	TOTAL PIO col 105	TOTAL ROUTINE CAPITAL EXPENDITURES col 106	TOTAL HOSPITAL OPERATING COST plus CAPITAL PAYOUT col 107	ANNUAL GAIN or LOSS col 108	ACCUM GAIN or LOSS col 109
1										
2										
3	June 1986									
4	June 1987									
5	June 1988	26,315,250	4,227,475	32,542,725	30,237,924	4,322,652	0	34,560,776	(2,018,051)	(2,018,051)
6	June 1989	26,427,673	3,487,547	31,915,221	32,108,098	4,179,799	2,172,242	36,460,139	(6,544,918)	(8,562,970)
7	June 1990	28,540,096	2,912,271	31,452,368	33,996,464	2,823,552	3,779,070	40,599,086	(9,146,718)	(17,709,688)
8	June 1991	28,848,154	2,377,091	31,225,245	35,995,147	2,826,148	1,791,743	40,613,038	(9,387,793)	(27,097,481)
9	June 1992	29,772,694	1,887,712	31,670,405	38,110,585	2,825,503	1,228,922	42,164,980	(10,494,575)	(37,592,056)
10	June 1993	30,829,704	1,879,352	32,909,056	40,168,525	2,821,994	1,365,468	44,355,987	(11,446,931)	(49,038,987)
11	June 1994	32,263,704	2,073,733	34,337,437	42,526,335	2,819,665	1,580,457	46,928,457	(12,591,020)	(61,630,007)
12	June 1995	33,680,538	2,172,632	35,833,170	45,025,873	2,816,742	1,693,347	49,535,962	(13,702,792)	(75,332,799)
13	June 1996	35,226,953	2,283,736	37,510,689	47,457,270	2,895,564	1,693,347	52,046,181	(14,535,492)	(89,868,292)
14	June 1997	36,763,991	2,392,594	39,156,585	50,243,266	2,690,499	1,693,347	54,827,112	(15,670,527)	(105,538,818)
15	June 1998	38,221,629	2,495,475	40,717,104	52,956,403	2,688,022	1,693,347	57,537,772	(16,820,668)	(122,359,487)
16	June 1999	39,900,221	2,614,312	42,514,532	56,084,120	2,683,364	1,743,151	60,690,635	(18,176,103)	(140,535,589)
17	June 2000	41,438,501	2,722,792	44,161,292	58,923,380	2,677,458	1,743,151	63,543,998	(19,382,707)	(159,918,296)
18	June 2001	43,493,561	2,869,053	46,362,614	62,202,503	2,953,105	1,743,151	66,898,759	(20,536,145)	(180,454,441)
19	June 2002	45,339,335	2,999,786	48,339,131	65,662,625	2,946,728	1,743,151	70,352,704	(22,013,573)	(202,468,014)
20	June 2003	47,268,167	3,138,499	50,404,665	69,314,312	2,938,531	1,743,151	73,995,994	(23,591,329)	(226,059,343)
21	June 2004	49,283,763	3,279,340	52,563,103	73,167,461	2,929,389	1,792,955	77,889,815	(25,326,712)	(251,386,056)
22	June 2005	51,253,459	3,418,685	54,672,144	76,865,917	2,921,502	1,792,955	81,580,374	(26,908,230)	(278,294,286)
23	June 2006	53,253,800	3,560,504	56,814,304	80,749,809	2,910,417	1,792,955	85,453,181	(28,638,877)	(306,933,162)
24	June 2007	55,335,924	3,708,195	59,044,119	84,828,371	2,900,832	1,792,955	89,522,158	(30,478,039)	(337,411,201)
25	June 2008	57,503,144	3,861,876	61,365,021	89,111,283	2,887,275	1,792,955	93,791,523	(32,426,502)	(369,837,703)
26	June 2009	59,993,072	4,039,022	64,032,094	94,007,083	2,867,342	2,988,260	99,862,685	(35,830,591)	(405,668,294)
27	June 2010	62,106,794	4,188,410	66,295,204	98,331,409	2,849,865	2,988,260	104,169,534	(37,874,330)	(443,542,624)
28	June 2011	64,298,723	4,343,403	68,642,126	102,854,653	2,830,485	2,988,260	108,673,398	(40,031,272)	(483,573,896)
29	June 2012	66,571,753	4,504,119	71,075,872	107,585,967	2,741,209	2,988,260	113,315,427	(42,239,555)	(525,813,451)
30	June 2013	68,926,667	4,670,784	73,599,661	112,534,922	2,788,153	2,988,260	118,311,335	(44,711,654)	(570,525,105)

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SCHEDULE 5

SCHEDULE OF CURRENT AND OBLIGATED CAPITAL COST
SUMMARY OF IMPACT OF MEDICARE CAPITAL PAYMENT PROPOSAL ON OBLIGATED HOSPITAL CAPITAL

Line	HOSPITAL FISCAL YEAR END col 62	MEDICARE CAPITAL with PHASE IN EVEN 5 Year col 63	MEDICARE CAPITAL PAYMENT VS HOSPITAL PRINCIPAL AND INTEREST PAYOUT: TOTAL PIO col 64	ANNUAL GAIN or LOSS col 65	ACCUM GAIN or LOSS col 66	MEDICARE CAPITAL PAYMENT VS HOSPITAL DEPRECIATION, INTEREST and OTHER: TOTAL DIO col 67	ANNUAL GAIN or LOSS col 68	ACCUM GAIN or LOSS col 69	******** VARIANCE ANNUAL GAIN or LOSS	******** VARIANCE ACCUM GAIN or LOSS
1										
2										
3	June 1986									
4	June 1987									
5	June 1988	4,243,596	4,322,852	(79,256)	(79,256)	4,836,544	(592,948)	(592,948)	-12.26%	-12.26%
6	June 1989	3,563,365	4,179,799	(616,434)	(695,690)	4,612,970	(1,049,605)	(1,642,553)	-22.75%	-17.36%
7	June 1990	3,082,066	2,823,552	258,536	(427,154)	4,589,233	(1,477,145)	(3,119,698)	-32.33%	-22.29%
8	June 1991	2,711,995	2,826,148	(114,153)	(541,307)	4,564,832	(1,852,837)	(4,972,535)	-40.58%	-26.76%
9	June 1992	2,380,950	2,825,503	(444,553)	(985,860)	4,442,804	(2,061,854)	(7,034,388)	-46.41%	-30.55%
10	June 1993	2,509,544	2,821,994	(312,451)	(1,298,311)	4,191,606	(1,682,123)	(8,716,512)	-40.13%	-32.02%
11	June 1994	2,656,980	2,819,685	(162,676)	(1,460,986)	4,041,003	(1,384,014)	(10,100,525)	-34.25%	-32.31%
12	June 1995	2,812,992	2,816,742	(3,750)	(1,464,736)	3,855,467	(1,042,475)	(11,143,000)	-27.04%	-31.73%
13	June 1996	2,988,104	2,895,564	92,540	(1,372,196)	3,773,112	(785,008)	(11,928,008)	-20.81%	-30.67%
14	June 1997	3,163,500	2,890,499	273,001	(1,099,195)	3,727,346	(563,846)	(12,491,854)	-15.13%	-29.31%
15	June 1998	3,334,331	2,888,022	446,309	(652,886)	3,672,095	(337,764)	(12,829,618)	-9.20%	-27.72%
16	June 1999	3,530,007	2,886,364	643,642	(9,243)	3,597,932	(67,925)	(12,897,543)	-1.89%	-25.85%
17	June 2000	3,712,558	2,877,456	835,101	825,857	3,512,456	200,103	(12,697,441)	5.70%	-23.78%
18	June 2001	3,949,57[illegible]	2,953,105	996,469	1,822,325	3,529,441	420,132	(12,277,309)	11.90%	-21.57%
19	June 2002	4,169,265	2,946,728	1,222,537	3,044,862	3,429,507	739,758	(11,537,551)	21.57%	-19.12%
20	June 2003	4,401,094	2,938,531	1,462,563	4,507,425	3,325,372	1,075,722	(10,461,829)	32.35%	-16.43%
21	June 2004	4,645,770	2,929,399	1,716,371	6,223,796	3,234,870	1,410,900	(9,050,929)	43.62%	-13.53%
22	June 2005	4,896,228	2,921,502	1,964,726	8,188,522	2,104,010	2,782,218	(6,268,711)	132.23%	-9.06%
23	June 2006	5,133,116	2,910,417	2,222,699	10,411,221	2,456,331	2,676,785	(3,591,926)	108.97%	-5.03%
24	June 2007	5,392,377	2,900,832	2,491,545	12,902,766	2,199,456	3,192,921	(399,005)	145.17%	-0.54%
25	June 2008	5,664,672	2,887,275	2,777,397	15,680,163	1,928,610	3,736,062	3,337,057	193.72%	4.41%
26	June 2009	5,975,874	2,867,342	3,108,532	18,788,695	1,766,247	4,209,627	7,546,684	238.34%	9.75%
27	June 2010	6,250,755	2,849,865	3,400,890	22,189,585	1,583,988	4,666,787	12,213,471	294.63%	15.47%
28	June 2011	6,538,262	2,830,485	3,707,777	25,897,362	1,383,686	5,154,576	17,368,047	372.52%	21.82%
29	June 2012	6,839,044	2,811,200	4,027,844	29,929,206	1,164,165	5,674,879	23,042,926	487.46%	28.27%
30	June 2013	7,153,632	2,788,153	4,365,479	34,290,685	905,721	6,247,911	29,290,837	689.83%	35.54%

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SCHEDULE 7 - Part 1 of 2

>>> S U M M A R Y S C H E D U L E <<<
IMPACT OF MEDICARE CAPITAL PAYMENT PROPOSAL ON OLD and NEW CAPITAL

Line	HOSPITAL FISCAL YEAR END col 86a	MEDICARE CAPITAL PAYMENT with PHASE IN col 87	MEDICARE CAPITAL PAYMENT vs PRINCIPAL INTEREST PAYOUT: TOTAL OLD FIO col 88	TOTAL NEW FIO col 89	TOTAL FIO col 90	ANNUAL GAIN or LOSS col 91	ROUTINE CAPITAL EXPEND. col 92	NET GAIN or LOSS col 93	ACCUM GAIN or LOSS col 94
1									
2									
3	June 1986								
4	June 1987								
5	June 1988	4,243,598	4,322,852	0	4,322,852	(79,254)	0	(79,254)	(79,254)
6	June 1989	3,563,365	4,179,799	0	4,179,799	(616,434)	2,172,242	(2,788,676)	(2,867,932)
7	June 1990	3,092,088	2,823,552	0	2,823,552	268,536	3,779,070	(3,510,534)	(6,378,466)
8	June 1991	2,711,995	2,826,148	0	2,826,148	(114,153)	1,791,743	(1,905,896)	(8,284,362)
9	June 1992	2,380,950	2,825,503	0	2,825,503	(444,553)	1,228,922	(1,673,475)	(9,957,837)
10	June 1993	2,509,544	2,821,994	0	2,821,994	(312,451)	1,365,468	(1,677,919)	(11,635,756)
11	June 1994	2,656,989	2,819,665	0	2,819,665	(162,676)	1,580,457	(1,743,133)	(13,378,888)
12	June 1995	2,812,992	2,816,742	0	2,816,742	(3,750)	1,693,347	(1,697,097)	(15,075,985)
13	June 1996	2,988,184	2,895,564	0	2,895,564	92,540	1,693,347	(1,600,807)	(16,676,792)
14	June 1997	3,163,500	2,890,499	0	2,890,499	273,001	1,693,347	(1,420,346)	(18,097,138)
15	June 1998	3,334,331	2,886,022	0	2,886,022	448,309	1,693,347	(1,247,038)	(19,344,176)
16	June 1999	3,530,007	2,886,364	0	2,886,364	643,643	1,743,151	(1,099,508)	(20,443,684)
17	June 2000	3,712,989	2,877,458	0	2,877,458	835,101	1,743,151	(908,051)	(21,351,735)
18	June 2001	3,949,573	2,953,105	0	2,953,105	899,468	1,743,151	(746,683)	(22,098,418)
19	June 2002	4,169,265	2,946,728	0	2,946,728	1,222,537	1,743,151	(520,614)	(22,619,032)
20	June 2003	4,401,094	2,938,531	0	2,938,531	1,462,563	1,743,151	(280,588)	(22,899,620)
21	June 2004	4,645,770	2,929,399	0	2,929,399	1,716,371	1,792,955	(76,584)	(22,976,204)
22	June 2005	4,886,228	2,921,502	0	2,921,502	1,964,726	1,792,955	171,771	(22,804,433)
23	June 2006	5,133,116	2,910,417	0	2,910,417	2,222,699	1,792,955	429,744	(22,374,689)
24	June 2007	5,392,377	2,900,832	0	2,900,832	2,491,545	1,792,955	698,590	(21,676,099)
25	June 2008	5,664,672	2,887,275	0	2,887,275	2,777,397	1,792,955	984,442	(20,691,657)
26	June 2009	5,975,874	2,867,342	0	2,867,342	3,108,532	2,988,260	120,272	(20,571,385)
27	June 2010	6,250,755	2,849,865	0	2,849,865	3,400,890	2,988,260	412,630	(20,158,755)
28	June 2011	6,538,262	2,830,485	0	2,830,485	3,707,777	2,988,260	719,517	(19,439,238)
29	June 2012	6,839,044	2,811,200	0	2,811,200	4,027,844	2,988,260	1,039,584	(18,399,654)
30	June 2013	7,153,632	2,788,153	0	2,788,153	4,365,479	2,988,260	1,377,219	(17,022,435)

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SCHEDULE 8 - Part 1 of 2

>>> S U M M A R Y S C H E D U L E <<<
TOTAL MEDICARE FPS PAYMENTS for OPERATING and CAPITAL COST
---> compared to <---
HOSPITALS OPERATING and CAPITAL COST for SERVICES COVERED by MEDICARES FPS

Line	HOSPITAL FISCAL YEAR END col 100a	NET TOTAL FPS REVENUE col 101	MEDICARE CAPITAL REVENUE col 102	TOTAL MEDICARE PAYMENTS col 103	HOSPITAL COST for SERVICES COVERED by FPS col 104	TOTAL PIO col 105	TOTAL ROUTINE CAPITAL EXPENDITURES col 106	TOTAL HOSPITAL OPERATING COST plus CAPITAL PAYOUT col 107	ANNUAL GAIN or LOSS col 108	ACCUM GAIN or LOSS col 109
1										
2										
3	June 1986									
4	June 1987									
5	June 1988	31,037,834	4,243,596	35,281,430	30,237,924	4,322,852	0	34,560,776	720,654	720,654
6	June 1989	32,798,001	3,563,365	36,361,366	32,108,096	4,179,799	2,172,242	38,460,139	(2,098,773)	(1,378,119)
7	June 1990	34,577,360	3,092,088	37,669,448	33,896,464	2,823,552	3,779,070	40,599,086	(2,929,638)	(4,307,757)
8	June 1991	36,691,418	2,711,995	39,403,413	35,895,147	2,826,148	1,791,743	40,613,038	(1,209,625)	(5,517,382)
9	June 1992	38,673,717	2,380,950	41,054,667	38,110,555	2,825,503	1,228,922	42,164,980	(1,110,313)	(6,627,696)
10	June 1993	40,607,362	2,509,544	43,116,905	40,168,525	2,821,994	1,365,466	44,355,987	(1,239,082)	(7,866,777)
11	June 1994	42,818,392	2,656,989	45,475,381	42,526,335	2,819,665	1,580,457	46,928,457	(1,453,076)	(9,319,853)
12	June 1995	45,158,157	2,812,992	47,971,149	45,025,873	2,816,742	1,693,347	49,535,962	(1,564,813)	(10,884,666)
13	June 1996	47,778,228	2,988,104	50,766,332	47,457,270	2,895,564	1,693,347	52,046,181	(1,279,849)	(12,164,514)
14	June 1997	50,407,627	3,163,500	53,571,127	50,243,266	2,890,499	1,693,347	54,827,112	(1,255,985)	(13,420,499)
15	June 1998	52,974,904	3,334,331	56,309,235	52,858,403	2,888,022	1,693,347	57,537,772	(1,228,537)	(14,649,036)
16	June 1999	55,907,563	3,530,007	59,437,570	56,084,120	2,886,364	1,743,151	60,693,635	(1,256,065)	(15,905,101)
17	June 2000	58,655,039	3,712,588	62,367,588	58,823,380	2,877,458	1,743,151	63,543,999	(1,176,401)	(17,081,502)
18	June 2001	62,191,993	3,948,573	66,141,566	62,202,503	2,953,105	1,743,151	66,898,759	(757,193)	(17,838,695)
19	June 2002	65,453,110	4,168,265	69,652,375	65,662,825	2,946,728	1,743,151	70,352,704	(700,329)	(18,539,023)
20	June 2003	68,955,612	4,401,094	73,356,706	69,314,312	2,936,531	1,743,151	73,995,994	(639,288)	(19,178,311)
21	June 2004	72,619,442	4,645,770	77,265,212	73,167,481	2,929,399	1,792,855	77,889,815	(624,603)	(19,802,914)
22	June 2005	76,227,950	4,886,226	81,114,177	76,865,917	2,921,502	1,792,855	81,580,374	(466,197)	(20,269,111)
23	June 2006	79,923,823	5,133,116	85,056,939	80,749,809	2,910,417	1,792,855	85,453,181	(396,242)	(20,665,353)
24	June 2007	83,804,481	5,382,377	89,186,858	84,629,371	2,900,832	1,792,855	89,522,158	(325,300)	(20,990,653)
25	June 2008	87,879,104	5,664,672	93,543,776	89,111,293	2,887,275	1,792,855	93,791,523	(247,747)	(21,238,400)
26	June 2009	92,524,921	5,975,874	98,500,795	94,007,083	2,867,342	2,988,260	99,862,685	(1,361,890)	(22,600,290)
27	June 2010	96,649,256	6,250,755	102,900,011	98,331,409	2,849,865	2,988,260	104,169,534	(1,269,523)	(23,869,814)
28	June 2011	100,963,310	6,538,262	107,501,572	102,854,653	2,830,485	2,988,260	108,673,398	(1,171,826)	(25,041,639)
29	June 2012	105,475,911	6,839,044	112,314,855	107,585,967	2,811,200	2,988,260	113,385,427	(1,070,572)	(26,112,212)
30	June 2013	110,195,887	7,153,632	117,349,519	112,534,922	2,788,153	2,988,260	118,311,335	(961,816)	(27,074,028)

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Chairman STARK. Thank you, Mr. Wood, very much.

Let me ask you if you have in your model, physical being or whatever, projections of what would happen if the PROPAC recommendations had been carried out and there was some increase?

I gather your assumption is with no increase in the prospective payment over the next 4 or 5 years?

Mr. WOOD. Under Gramm-Rudman.

Chairman STARK. Well, that you are anticipating no increase in the DRG rates.

Mr. WOOD. That is correct, sir.

Chairman STARK. Now, let's assume there was—PROPAC suggested last year 2 percent and change, I think. Did you run any with a 2- or 3-percent annual increase?

Mr. WOOD. I did run what the market basket approach was, that would run between a 6-percent increase and 4.5-percent increase. Each year was different. I ran that one for a 30-year period.

Chairman STARK. Did you come out of the woods on that?

Mr. WOOD. No.

Chairman STARK. Getting closer?

Mr. WOOD. Naturally came closer. The problem with the Gramm-Rudman is that when you have a number of years without an increase, you have a compounding effect.

Chairman STARK. Let's set Gramm-Rudman aside. If you cranked this through with the administration's capital proposal melding it in with DRG's, did you make assumptions the DRG's might go up according to ProPAC, 2 or 3 percent and that didn't get you anywhere close?

Mr. WOOD. No, sir.

Chairman STARK. What did you do by cranking in an increase in indirect medical education costs? Did that——

Mr. WOOD. I held the indirect medical education, we get 11.5 now and my reading was that will be reduced to 8 percent so I froze it at 8 percent and did not increase it.

Chairman STARK. Is that significant enough so if that were allowed to increase in some relation to the rest of the DRG rates, that that would get you out?

What I guess I am getting at is, did you run any scenario that didn't take you off the screen, that you came out about right, short of your present capital reimbursement schedule?

Mr. WOOD. Not at this time.

Chairman STARK. Do you think there is any? You are probably more familiar with the numbers according to your hospital.

Mr. WOOD. I believe there probably is a number that will work. I believe the big problem is that we are one of those hospitals that is at the beginning of its capital. A portion of the hospital failure had to be replaced, or refurbished, which was approved by local and State planning agencies, et cetera, and the Joint Commission on Accreditation of Hospitals said that we needed to replace. We did that.

This puts us at our highest peak of capital.

Chairman STARK. I guess you just went into a big building program——

Mr. WOOD. Yes, sir.

Chairman STARK [continuing]. To expand the number of beds.

Mr. WOOD. No, we did not expand. We contracted the numbers of beds.

We replaced buildings built in 1915 and 1927.

Chairman STARK. Did you anticipate occupancy at that point?

Mr. WOOD. Yes.

Chairman STARK. Are you getting it?

Mr. WOOD. No, sir; we are short.

Chairman STARK. How short?

Mr. WOOD. Probably about 8 percent lower than we planned.

Chairman STARK. You mean eight points?

Mr. WOOD. Yes, sir.

Chairman STARK. What happens to your estimate if you hit your occupancy targets?

Mr. WOOD. What happens to——

Chairman STARK. Have you projected that? If you take all—let's assume a rosy scenario here and say that the DRG rates went up a couple points and indirect medical education stayed at 11 and increased a little and occupancy hit the targets.

How do you come out? Again, assuming——

Mr. WOOD. Assuming——

Chairman STARK. Assuming the administration's program.

Mr. WOOD. Assuming——

Chairman STARK. Throw 7-year transition in there. I am trying to see if you did enough "what-ifs" with your program.

Mr. WOOD. The "what-ifs" we ran under 7 year and 10 year. Naturally they are better than 4 or 5 year.

They just at this point don't particularly bring us out of the woods in total, but they do come closer.

Chairman STARK. It would be interesting to see. This committee did not want to freeze DRG rates. I think generally we wanted to increase them and we may. I don't know what will happen in time.

We wanted to give some increase for indirect medical education. I don't know what you did on disproportionate share.

Mr. WOOD. That does not affect us.

Chairman STARK. Indirect medical education?

Mr. WOOD. That and direct medical education, we have two other units excluded.

Chairman STARK. I am trying to get to a rosy scenario and say if you hit your occupancy targets, how long a transition do you need to get out of the woods?

I have a hunch that you could go back and play with these numbers a little bit and see in light of what the administration seems to be wanting to do, and while it seems—you can make your own guesses about whether we get to a 20-year transition or whether we will stay closer to 4—but let's assume that we have to do something like, for example, begin to deal as was suggested earlier that we may have to see capital, the wrong hospitals close.

Maybe we should close the ones that are old and don't have a high capital cost, and you will have the patients and get the occupancy up where it should be. Will that get you out of the woods?

I am looking for a variety of directions to go and see what happens. You have a unique ability to model it for us, and the willingness to be very candid about it.

Mr. WOOD. I would be most happy to run further models of a 7-year or 10-year span and pick other DRG proposals. I would be happy to send them to you.

Chairman STARK. I don't know if out of that we would find a pattern emerging but it might be well worth it.

Do you know the exact number of years you need in transition to make yourself whole?

Mr. WOOD. I would say somewhere between 14 and 15 would probably do it.

Chairman STARK. Your projections are all on a cash basis if I—if you had to stay whole on a cash accounting basis?

Mr. WOOD. We do not under these proposals, I am not whole on a cash basis. I have not considered—the schedules show depreciation. What I have mentioned was that the principal and interest will not be met.

Chairman STARK. Your depreciation is not greatly in excess of your loan amortizations?

Mr. WOOD. The principal payment is lower in the front years and depreciation is higher in the front. Over the total life the two will come close to each other. But they have a different amortization schedule.

Chairman STARK. If you raised enough in contributions, would that have an affect?

Mr. WOOD. We did a major contribution program to put up the equity portion of this building.

However, we believe that the Medicare Program should pay its share for its patients and that the capital contribution from a non-Medicare area should not subsidize the Medicare patient.

Chairman STARK. I am inclined to agree with you. I just wonder whether volunteerism might be a——

Mr. WOOD. It is just not——

Chairman STARK [continuing]. Might solve your problem?

Mr. WOOD. There is not enough charity to solve this particular problem.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Do you anticipate the Catholic Hospital Association will be in a position to offer us specific alternatives to the administration's plan any time soon?

Mr. WOOD. I think the Catholic Hospital Association is working by pulling together this type of information. I said I think it is a very difficult—Health and Human Services since October 1, 1984, was supposed to have given us a report and you a report. Apparently they are struggling with it.

So I think, also, are we.

Mr. GRADISON. That is a very fair answer.

Thank you very much.

Chairman STARK. Mr. Wood, I have some questions that the staff drafted for me and I will ask that they submit them to you in writing and see if you could respond just in the interests of time for today. I know it is snowing out there and people are anxious to beat the rush hour.

I would like to ask the staff to ask you to respond to questions.

Mr. WOOD. I would be happy to do so.

[The information follows:]

Question. Under Schedule 8, Part II, what portion of the loss is attributed to losses on the operating side versus capital?

Answer. Scenario 2, Schedule 8 assumes an adjustment of PPS rates of 6.1% in 1987 and 6% in 1988. It further assumes the continuation of direct medical education and indirect medical education payments at current level.

DRG Payment	$25,433,391
Direct medical Education	2,865,462
Indirect Medical Education	2,738,981
Subtotal	31,037,834
Hospital Estimated Cost	(30,237,924)
Surplus	799,910
Capital:	
Hospital Interest and Depreciation	4,836,544
Medicare Capital Payment	(4,243,596)
Shortfall of Capital	592,948
Operating Surplus	799,910
Capital Shortfall [1]	592,948
Total	206,962

If you move to the fifth year of the Capital fold in where we are wholly under the Federal payment, we would receive the following:

Depreciation and Interest (Actual)	4,442,804
Capital Payment (After fold in)	(2,380,950)
Short fall [2]	2,061,854

[1] This is first year of transition for Good Samaritan therefore it is 80% of our actual cost.
[2] This short fall exceeds the $799,910 surplus.

Question. Under your table, in Schedule 8 you predict a deficit of about $2 million in 1988. That could be corrected by what percentage increase in your charges (2% overall, 3% non-Medicare).

Answer. An increase to all patients of 2% is not realistic since to increase the price for a Medicare patient does not produce any additional revenue because the DRG weight and payment for value of one sets the payment irregardless of the price.

The $2,098,773 deficit would require a rate increase to all non-Medicare and non-Medicaid patients of $15.50 per day. This, I believe, is unacceptable to the other purchasers of care.

Question. You have annual expense of about $100 million in 1985. What was your surplus or deficit?

Answer. Our testimony was centered around the Medicare Program beneficiaries and the payment to the Hospital by the Federal Government.

Our first year in PPS ended June 30, 1985. Our Capital Cost was only 50% of the project because the building was not occupied for the full year. Our full cost will be in Fiscal 1986, thus our cost was lower.

	Million
Medicare Inpatient Revenue	$32.0
Contractual Adjustment	(1.5)
Medicare Portion of Cost	(28.0)
Surplus [1]	2.5

[1] DRG & Medical Education plus Capital Pass Thru.

This surplus is the first year phenomenon of PPS as the length of stay was shortened. Hospital rates were set to accumulate surplus to pay a portion of bonds. The hospital called $5 million of bonds on February 1, 1986.

Chairman STARK. Our next witnesses will comprise a panel of the American Healthcare Institute, represented by Merlin DuVal, president, accompanied by J. Knox Singleton, president, Fairfax

Hospital Association; Coalition for Fair Capital Reimbursement, Marvin Rushkoff, chief financial officer, Mount Sinai Hospital; Greater New York Hospital Association, represented by Kenneth Raske, accompanied by Daniel J. Rinaldi, treasurer, Catholic Medical Center of Brooklyn and Queens.

I will ask each of the three groups to summarize your position in 5 minutes. Each of you have 5 minutes and we will try to let you respond in more detail as the committee may wish to question you.

I will call you in the order that you appear here.

Mr. DuVal.

STATEMENT OF MERLIN K. DUVAL, M.D., PRESIDENT, AMERICAN HEALTHCARE INSTITUTE, ACCOMPANIED BY J. KNOX SINGLETON, PRESIDENT, FAIRFAX HOSPITAL ASSOCIATION

Dr. DUVAL. Thank you, Mr. Chairman.

I am Merlin DuVal. You have my full statement in front of you and as a consequence, and in deference to your interests, I will not make a comment this afternoon.

I represent the American Healthcare Institute, the nation's largest system of not-for-profit voluntary hospitals. In view of your interest specifically in the impact of the administration's proposal, I have brought one of my CEO's, president and CEO of the Fairfax Hospital Association, Knox Singleton, to explain to you what the impact of that proposal would be, and I would yield to him if you would accept that.

Chairman STARK. I would be happy to. Thank you.

Mr. Singleton.

Mr. SINGLETON. Thank you, Mr. Chairman.

Chairman STARK. Do we have your testimony?

Mr. SINGLETON. No, you do not.

I am Knox Singleton, president of the Fairfax Hospital Association. The association is a nonprofit community organization that is located in northern Virginia just about 10 miles to the south of our location now.

We operate four hospitals principally in Fairfax County, but also in other areas of northern Virginia comprising approximately 1,200 beds. Three of them are primarily small health care facilities and one is a large referral institution, namely the Fairfax Hospital.

We have been, over the last several years, bringing on a number of different expansions and projects which have fundamentally comprised a major investment in our community, and we wanted to appear before you today, Mr. Chairman, to outline to you the facts on two projects which are planned to come on line in 1987.

One is the replacement of one of our hospitals, the Commonwealth Hospital, which was basically deemed to be obsolete by the State architect and which is being replaced basically on a bed-for-bed basis and is due to be completed approximately in January 1987.

The other project is a renovation and minor expansion of the Fairfax Hospital which is the tertiary care hospital and will basically provide new operating rooms and other ancillary support facilities.

Neither of these projects has any expansion of the capacity. In both instances, any beds that are involved in these projects are fundamentally simply replacement of existing beds which, for one reason or another, are obsolete.

Both projects total approximately $50 million together. Under current rules, these projects would expand our reimbursement from $4.1 million to approximately $5.7 million.

As you may expect, we have a great deal of interest in the administration's proposal. Over the past several days we have compiled a model which reflects the impact of the administration's proposal upon the reimbursement which we would receive.

We fundamentally developed the model using the assumptions which we have been using in planning our current capital plan over the next 5 years, and second, we used assumptions which were necessary to translate the administration's proposals into a proposed or expected reimbursement level. We think these assumptions are conservative and in general are in the middle of the road.

They basically gave us two significant conclusions: One and foremost, in our mind, the fact we would experience approximately a 36-percent decrease in the first year of the transition in our Medicare reimbursement for capital only. The $3.66 million which we would expect would be approximately $2.053 million less than we would receive under current rules.

At the same time, if we look at the 1991 model which we have constructed it indicates that we would expect in excess of a 55-percent decrease in our expected capital reimbursement, which would be a decrease in excess of $3.3 million over the levels we expect at the present time.

Currently we anticipate that our operating margins which have averaged between 4 and 6 percent over the last 4 to 5 years, and which are projected to be between 1 and 4 percent over the next 5 years, in year 5 would be virtually eliminated under the proposals that have been made given the assumptions which have been in place to date.

One last point that I would make is that we projected under the administration's plan approximately a $320 per discharge Medicare capital payment. The cost to our organization, the replacement project, is in excess of $680 per Medicare discharge or approximately a difference of over 215 percent.

Obviously, the impact of these changes are very significant to us and while we only have approximately 26 percent Medicare patients they will represent a substantial impact and hardship on our ability to meet the health care needs of our community.

Thank you.

[The prepared statement follows:]

Statement of the

AMERICAN HEALTHCARE INSTITUTE

Mr. Chairman, I am Merlin K. DuVal, M. D., President of the American Healthcare Institute. The American Healthcare Institute represents a national network of voluntary healthcare systems that provide quality hospital and other health services in communities throughout the United States. The shareholders who make up this national network--known as American Healthcare Systems--consist of some 35 systems linking 500 hospitals and 950 affiliate organizations across 44 States and the District of Columbia. It is the largest network of non-profit hospitals in the world. One of the most important innovations happening in healthcare today is the growing trend toward creation of hospital systems through which not-for-profit hospitals can take advantage of economies of scale and management talent to provide the American people with high quality health care at an affordable price. On behalf of our member systems, I appreciate this opportunity to share our views about possible changes in Medicare's payment policies toward the capital needs of health facilities.

First of all, Mr. Chairman, we would like to emphasize to the Committee the importance of capital to those who provide health services in both inpatient and ambulatory settings. Though not a major portion of total health spending, capital is a driving force in shaping both the quality of and access to medical care. Capital investments are critical to community-based institutions, if they are to serve their principal purpose of providing a wide range of needed health services in a changing environment.

Capital projects are undertaken primarily for the maintenance of facilities and for the replacement of worn-out plant. But,

capital is also required to facilitate the transformation of our industry into more efficient care delivery units. Capital is, in a phrase, Mr. Chairman, a legitimate and absolutely essential cost of doing business. For these reasons, we urge the Committee to consider its possible actions relating to capital under medicare very carefully.

Unfortunately, Mr. Chairman, some casual observers of what is happening in today's health care industry continue to believe that the bulk of capital spending goes to support expanded capacity and unneeded new services. Nothing could be farther from the truth. There's a new competitive environment out there, brought about in large part by governmental and private purchasers of care who will simply not support--through their payment practices--wasteful uses of capital resources. Shorter lengths of stay, and the movement of much patient care to ambulatory settings, (which reduce hospital occupancy rates and revenues), competition from within the health industry, and prospectively fixed rates of payment mean that any hospital that, today, adds unneeded capacity or unwanted services is on the road to bankruptcy.

Most capital projects, therefore, are undertaken only when needed and for some of the following reasons:

- renovation of older, existing facilities to assure continued availability of basic health services;
- development of ancillary and support services;
- construction of lower cost ambulatory alternatives to certain kinds of inpatient services;
- reorganizations and consolidations of existing inpatient services, and the introduction of new or highly

specialized capital-intensive units (e.g., trauma centers, burn units, etc.); and,

- mergers and acquisitions of separate facilities into more cost-effective units.

Mr. Chairman, the members of the American Healthcare Institute will support efforts to introduce marketlike incentives into hospital capital investment decisions. We recognize, for example, that the prospective payment system for operating costs has already resulted in deferring many capital decisions--particularly those relating to the purchase of new equipment--because an expansion of hospital services through such capital investments must take into account the accompanying increases in operating costs. (In fact, Mr. Chairman, we are also concerned about the impact of some current DRG pricing decisions on the development and diffusion of some of the newer, capital-dependent technologies where the the payment rates do not cover the associated operating costs involved, thereby setting the stage to deny Medicare patients access to the benefits of these new medical developments.)

Capital costs differ from operating costs in two important ways. First, capital costs are unevenly distributed among the hospitals and other facilities participating in the Medicare program and vary, over time, for any individual facility. This is largely due to the fact that major capital expenditures, particularly for replacing and modernizing plant or major fixed equipment, occur infrequently. Hospitals that have recently initiated or completed large capital projects may, in any one year--have capital costs amounting to over 20 percent of their total expenses. Older facilities, which face major capital projects in the future, can have current capital costs amounting to 3 percent or less of their current total expenses. For

these reasons, Mr. Chairman, many of our members--and especially those with major capital cost commitments--are very concerned about what Congress may do in the capital area. We believe that fairness demands that such costs--which were incurred in good faith under rules to which the Government was a party--must be fully recognized as burdens already incurred. Proposals to pay for capital costs incurred in previous years under Medicare on the basis of some type of "average" rate of payment could cause major financial problems for hospitals with capital costs above such an "average", while providing potential windfalls for those whose capital costs are below the average rate of payment for such expenses.

Second, capital costs are fixed costs, incurred over lengthy time periods, that must be covered from current and future earnings. Hospitals must meet principal and interest payments on funds borrowed to finance capital improvements--just as all of us must meet mortgage payments on our homes and car payments on our auto loans. Even the Federal Government must meet its debt service obligations--if it intends to remain a credit-worthy borrower in the marketplace.

Any substantial reduction in the level of payments for existing capital obligations would require that hospitals find revenues from other sources--if that is possible in an increasingly competitive private market environment. Further, facing a freeze - if not a cutback - in Medicare payments, will force hospitals to further reduce their variable operating costs. The latter would probably take the form of abrupt personnel layoffs, reductions in staffing patterns unrelated to service volumes, or severe wage and fringe benefit cuts. Such steps cannot but seriously affect both access to and the quality of the services now provided in the communities we serve. Any major changes in capital policy for Medicare, therefore, absolutely must provide

adequate time for the providers of services to adapt to changing financial circumstances dictated by the new policies, if major disruptions in services are to be minimized. Capital costs are so buried in the cost structure of our institutions that time is needed before our managers can regain control of such costs in a new payment environment. After careful study, our members believe that at least a decade will be needed in any reasonable transition from one capital payment approach to another.

Mr. Chairman, the members of the American Healthcare Institute will support the notion of incorporating Medicare's payment for capital into patient care rates under PPS. We recognize that such a change will complete the movement of the Government's program from a cost reimbursement system to one in which the suppliers of services are free to compete and employ their resources in response to the wishes of the marketplace. Our support for these steps, however, depend upon a willingness on the part of Government not to effect such changes in potentially very damaging ways.

We ask you, in considering the recommendations of the Administration about capital under Medicare, to assure that:

- No redefinitions are made of "capital" when it comes to establishing a base period from which any DRG adjustments are to be made;
- The impact of any new rules be carefully weighed to take account of the consequences of new payment policies on prior capital obligations already made by community hospitals; and that,
- Adequate time be allowed in a transition from present policies to any new ones in order to minimize disruptions in the availability of a full range of services to Medicare patients.

Thank you, very much.

Chairman STARK. Thank you very much, Mr. Singleton.

We will hold our questioning until the entire panel has been heard.

Mr. Rushkoff, would you like to proceed?

STATEMENT OF MARVIN RUSHKOFF, CHIEF FINANCIAL OFFICER, MOUNT SINAI HOSPITAL, COALITION FOR FAIR CAPITAL REIMBURSEMENT

Mr. RUSHKOFF. I will summarize my statement.

Mr. Chairman, members of the subcommittee, I am Marvin Rushkoff, chief financial officer at Mount Sinai Hospital in New York. I am pleased to be able to testify today on proposals for including capital-related costs in the medicare prospect payment system.

A little more about my background: I am a C.P.A., I have an M.B.A. and I teach financial management as an associate professor of the City University of New York.

I am here on behalf of the Coalition for Fair Capital Reimbursement, a group of major teaching hospitals with vital interests at stake on this issue.

The coalition includes the following institutions: University of Minnesota hospitals and clinics; University of Virginia hospitals; Stanford University Hospital; University of Michigan hospitals; University of Washington hospitals; Brigham and Women's Hospital; Montefiore Medical Center; Mount Sinai Medical Center; the New York Hospital; the Presbyterian Hospital at Columbia-Presbyterian Medical Center; and Saint Luke's-Roosevelt Hospital Center.

Each of these nationally recognized institutions has undertaken a mandatory renovation project involving substantial capital obligations in good faith reliance upon the law in effect prior to enactment of the PPS. I use the term "mandatory" to apply to correcting life safety code violations and replacing aging and outmoded facilities.

For example, the majority of Mount Sinai's plant being replaced was built in 1902 and planned for in the late 1800's. One example of a truly difficult situation is the underground thoroughfare at this complex. We have one main tunnel through which patients with life-threatening conditions and, patients going to and from surgery pass, along with garbage, patient meals, dirty laundry, staff and visitors.

Projects of the magnitude of Mount Sinai's require years for planning and execution. Planning for the Mount Sinai project began in 1977. The internal planning stage required over 2 years, the certificate of need application for the project was filed in 1981.

I believe that it is very significant that the medical center like the other coalition members undertook significant steps toward completion of its project including obligation of substantial sums prior to the enactment of PPS. Mount Sinai expended over $8.5 million in architectural and consulting fees prior to 1983.

Due to the project scope and earlier delay caused by a one-year moratorium on certificate of need approvals in New York, the project will not be completed entirely until 1991, which is after the proposed phase-in period.

The impact of the administration proposal upon Mount Sinai would be severe. Under the administration proposal for capital the medical center would experience large operating deficits for many years unless services were substantially curtailed.

The losses under the previously known proposal are alarming. Using a 7-year phase in and 6-percent add-on factor would at its peak in 1992 create a capital shortfall of roughly $24 million. The capital shortfall for the decade 1991 to the year 2000 would be roughly $211 million. Mount Sinai would have to severely cut charity care and new programs to meet our debt obligation schedule.

In conclusion, we believe that it would be very unfair and dangerous to change the rules with respect to necessary projects of this magnitude in midstream without providing an adequate transition mechanism for obligations committed before the enactment of the PPS.

We commend the chairman and the subcommittee for holding hearings on this important change in medicare policy, and urge the subcommittee to introduce appropriate legislation.

I would be happy to answer any questions you might have with respect to my testimony.

[The prepared statement follows:]

TESTIMONY OF

MARVIN RUSHKOFF

ON BEHALF OF THE COALITION FOR FAIR CAPITAL REIMBURSEMENT

BEFORE THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FEBRUARY 24, 1986

Mr. Chairman and Members of the Subcommittee, my name is Marvin Rushkoff, Chief Financial Officer of the Mount Sinai Medical Center. I am pleased to be able to testify today on proposals for including capital-related costs in the Medicare prospective payment system.

I am here on behalf of the Coalition for Fair Capital Reimbursement, a group of major teaching hospitals with vital interests at stake on the capital reimbursement issue. The Coalition includes the following institutions: University of Minnesota Hospitals and Clinics, University of Virginia Hospitals, Stanford University Hospital, University of Michigan Hospitals, University of Washington Hospitals, Brigham and Women's Hospital, Montefiore Medical Center, The Mount Sinai Medical Center, The New York Hospital, The Presbyterian Hospital at Columbia-Presbyterian Medical Center, and St. Luke's-Roosevelt Hospital Center. Each of these nationally recognized institutions has undertaken a mandatory renovation project involving substantial capital obligations in good faith reliance upon the law in effect prior to the enactment of the prospective payment system.

At the outset, I would like to say the Coalition fully recognizes that national health policy -- like so many other areas of our Federal budget -- must reflect the changing circumstances of rising deficits. The Coalition does not wish to obstruct either legitimate deficit reduction efforts or the reasonable incorporation of capital reimbursement into the prospective payment system. What the Coalition does wish to convey to Members of the Subcommittee, however, is that the Administration's proposal for capital reimbursement, as set forth in the President's

budget for FY 1987, is grossly deficient in its failure to provide an adequate transition mechanism for the renovation projects already underway at hospitals such as those of the Coalition. The Coalition members face severe financial harm unless an adequate transition is permitted for major renovation projects that predate the advent of the prospective payment system.

As pointed out by the Washington Post in its editorial of February 19, 1986, to fold capital costs into PPS without understanding the specific consequences of the new reimbursement policy makes no sense. Despite a legislative directive to study the matter and to report to Congress by October 1985 on methods for incorporating capital into the prospective payment system, the Administration is threatening to implement a prospective reimbursement methodology for capital without releasing data on the effects of its proposal. Before the Administration is permitted to adopt a new reimbursement system for capital, there should be a thorough understanding of its impact on hospitals around the country. The members of the Coalition know that they will have to curtail their services sharply if capital is brought under the prospective payment system without appropriate transition measures.

To illustrate the need for transition relief, I would like to describe the Mount Sinai project and the other Coalition projects. Then, I would like to provide some preliminary estimates of the financial impact upon Mount Sinai of an abrupt change to a prospective system. The Coalition intends to submit more detailed information on financial impact to the Subcommittee in the near future -- the data is presently being assembled.

The Mount Sinai Medical Center is one of the nation's largest hospitals, with over 1200 beds. The Mount Sinai renovation project is a major one designed to bring a severely outdated facility up to present standards. The total cost of the project is estimated at $488 million. Due to the age of its 26 separate structures --

most date from the 1904-1922 period -- the Medical Center has repeatedly been cited for life safety code and other accreditation deficiencies.

This project is necessary in order for the Medical Center to continue in its vital role in its community. By its size alone, Mount Sinai provides the volume of services typically furnished by seven average community hospitals. In addition, the Medical Center serves as a major tertiary care center for its region, providing many services unavailable in most community hospitals. Like other Coalition members, it is also heavily committed to serving the poor -- last year, for example, it provided $15 million in charity care. Seventeen percent of its patient days and 47 percent of its outpatient visits were for Medicaid patients. The Medical Center, in effect, functions as the "family physician for East Harlem."

Projects of the magnitude of Mount Sinai's require years for planning and execution. Planning for the Mount Sinai project began in 1977. The internal planning stage required over two years. The Certificate of Need application for the project was filed in 1981. I believe that it is very significant that the Medical Center, like the other Coalition members, undertook significant steps toward the completion of its project, including the obligation of substantial sums, prior to the enactment of prospective payment. The Medical Center expended over $8.5 million in architectural and consultant fees for the project prior to 1983. Due to the project's scope and an earlier delay caused by a one-year moratorium on Certificate of Need approvals in New York State, the project will not be completed entirely until 1991.

As is the case of all the Coalition members, Mount Sinai is making a very substantial equity contribution to its project. Mount Sinai is investing $110 million in its project. The average equity contribution for Coalition members is approximately 30 percent of their projects' costs. This fact typifies the Coalition members' efforts to hold down financing costs by substantial con-

mitments of whatever funds they have available or can raise through development campaigns.

The projects of the other Coalition members are similar in scope, timing, and necessity. The average age of the structures being renovated is approximately 55 years. The average project cost is approximately $250 million. The average Certificate of Need filing date for the Coalition projects was 1980, the average approval date was 1981. The planning stage for each of these projects has entailed considerable expenditures for architects, engineers and other consultants prior to the enactment of prospective payment. The average commencement date of construction was 1983, and the average completion date is 1988.

It is important to recognize that under traditional Medicare reimbursement principles, which require capitalization of all construction period costs, the costs of these projects would not begin to be reimbursed until the projects are completed. Thus, because the average completion date is 1988, basing reimbursement during a transition period upon 1986 costs generally would deny any recognition of the costs of these projects.

The impact of the Administration's proposal upon Mount Sinai would be severe. Under the Administration's proposal for capital, the Medical Center would experience large operating deficits for many years unless services were substantially curtailed. The Medical Center has made some rough estimates of the dollar impact of the Administration's proposal compared to continued reimbursement for capital based upon actual costs. Even assuming very favorable Medicare reimbursement policies in the future (the estimates and the assumptions upon which they are based are set forth in the attachment at the end of this statement), the losses under the capital proposal are alarming. At its peak in 1992, the capital shortfall would be roughly $24 million. The capital shortfall for the decade 1991-2000 would be roughly $211 million in the aggregate. Although it is impossible to predict the impact upon the Medical Center's operating margin, since services would

have to be curtailed to make up these staggering shortfalls, it is important to realize that the Medical Center already operates at a loss due to its strong commitment to indigent care. Mount Sinai operates a number of programs -- such as its sickle cell anemia, drug treatment, and adolescent obstetrical programs -- which lose substantial sums. The Medical Center would have to curtail these and other worthwhile programs in order to offset reimbursement shortfalls of this magnitude. Savings of $25 million per year to offset the losses under the Administration's capital proposal simply cannot be realized through economy measures without significant reductions in services. Thus, the ultimate impact of the Administration's proposal would be in reduced services to the community.

In conclusion, we believe it would be very unfair and dangerous to change the rules with respect to necessary projects of this magnitude -- for which obligations were committed before the enactment of prospective payment -- in midstream without providing an adequate transition mechanism. Since the Coalition members will have capital costs averaging roughly 18 percent of operating costs, have substantial Medicare utilization (approximately 30 percent on average), and, typically, already operate at or near a loss, the new reimbursement policy as proposed by the Administration threatens them with great harm. Because of the size of these projects, their mandatory nature, the good faith reliance upon prior law, and the important role such institutions play, we believe that the Medicare share of these projects should be reasonably funded in order to permit these hospitals to continue to function adequately in the years ahead. We commend the Chairman and the Subcommittee for holding hearings on this important change in Medicare policy and urge the Subcommittee to introduce appropriate legislation.

MOUNT SINAI MEDICAL CENTER
ESTIMATED SHORTFALL IN REIMBURSEMENT
FOR CAPITAL-RELATED COSTS
[By fiscal year, in millions of dollars]

1987	1988	1989	1990	1991	1992	1993
1	1	13	18	20	24	24

1994	1995	1996	1997	1998	1999	2000
22	21	21	20	20	20	19

Total aggregate shortfall 1991-2000 211

ASSUMPTIONS:

1. Capital add-on assumptions. The add-on for capital-related costs would be a $400 addition to the nonlabor related standardized amounts. Thus, the capital add-on would be adjusted by the DRG weights and the indirect medical education adjustment factor, but not the wage index. There would be a linear five-year transition period, with the hospital-specific portion of the add-on beginning at 80 percent in 1987 and declining by 20 percent per annum to zero in 1991. The hospital-specific portion of the add-on would be based upon actual costs in each year rather than 1986 or some other base period. Interest income on funded depreciation and gifts would be subject to offset against interest expense.

2. Prospective payment system assumptions. The DRG payment rates would be increased by 4 percent per annum for inflation. The present indirect medical education adjustment factor (11.59 percent for each 0.1 increase in the resident to bed ratio) would remain unchanged.

3. Hospital-specific assumptions. Despite the fact that admissions have declined by 9 percent for the period 1982-85, discharges are assumed to remain constant through the year 2000. The Medical Center's case mix index, which has not changed in several years, is assumed to remain constant. The ratio of capital costs allocable to Medicare inpatients is assumed to remain at its historical level of 43 percent.

COMMENT: Based upon the foregoing assumptions, this estimate of the shortfall in reimbursement under the projected prospective payment method for capital compared to a continued passthrough for capital is believed to be quite conservative. However, it must be stressed that these figures represent only a rough estimate. More refined data will be submitted in the future.

March 12, 1986

Fact Sheet on Coalition for Fair Capital Reimbursement

- The Coalition for Fair Capital Reimbursement (CFCR) is an ad hoc coalition of major teaching hospitals with significant interests at stake in the incorporation of capital-related costs in the Medicare Prospective Payment System (PPS). Each of the CFCR member institutions has recently undertaken a major mandatory capital replacement project involving substantial commitments prior to the enactment of PPS.

- All CFCR member institutions will face drastic shortfalls in capital reimbursement under current proposals for incorporating capital in PPS. Bond obligations entered into to finance these projects typically involve repayment schedules of 20 to 30 years in duration. Special transition provisions are needed to recognize the CFCR institutions' good faith reliance on current law in undertaking these projects.

- CFCR is concerned that the most damaging capital proposal under consideration, proposed by the Department of Health and Human Services (HHS) may be implemented by regulation if Congress does not act soon on the capital issue. CFCR recommends that Congress consider the imposition of a moratorium on such administrative action in order to avoid the devastating impact of the HHS proposal.

- CFCR recommends the establishment of a pool of funds to meet extraordinary capital needs based on mandatory major capital replacement projects undertaken prior to PPS. The funds could be made available through a small across-the-board reduction in future DRG-rate increases. Preliminary analysis shows that a reduction of as little as 0.1 percent would be sufficient to redress the problem faced by CFCR member institutions.

- The following institutions are members of CFCR:

Brigham and Women's Hospital	Stanford University Hospital
University of Michigan Hospitals	St. Lukes-Roosevelt Hospital Center
Montefiore Medical Center (New York)	University of West Virginia Hospital
Mount Sinai Medical Center (New York)	University of Washington Hospital
The New York Hospital	University of Virginia Hospital
Presbyterian Hospital at Columbia Presbyterian Medical Center	University of Minnesota Hospital and Clinic

Chairman STARK. Thank you very much, Mr. Rushkoff.
Mr. Raske.

STATEMENT OF KENNETH E. RASKE, PRESIDENT, GREATER NEW YORK HOSPITAL ASSOCIATION, ACCOMPANIED BY DANIEL J. RINALDI, TREASURER, CATHOLIC MEDICAL CENTER OF BROOKLYN AND QUEENS, INC.

Mr. RASKE. Thank you, Mr. Chairman.

I am Ken Raske, president of the Greater New York Hospital Association. Thank you very much, Mr. Chairman and members of the committee, for allowing me and my colleague, Daniel Rinaldi, treasurer of the Catholic Medical Center of Brooklyn and Queens, Inc. to be present today.

We will make it short, Mr. Chairman. The point of our testimony is to expose to you three or four parameters that we think would be helpful in the design and measurement of the efficacy of any capital reimbursement policy and through the presentation by my colleague, Dan Rinaldi, put that into hard-life context for you so that you have a good feel for these proposals. We can make this very short.

The first one, Mr. Chairman, is simply that the problem of downsizing of hospital facilities, is incompatible with the administration's proposal.

The problem is that you don't, for example, get 100 percent financing of an 80 percent down-sizing of a facility. If you did, in the current environment of excess capacity, then there would be more tangible meaning to the issue of the administration's proposal, but because you are dealing with fixed add-ons, the more you downsize, the proportionate amount of less reimbursement one will get, assuming there is some sort of functional relationship between admissions and beds.

The second point, Mr. Chairman, is simply one of nomenclature. It is called disproportionate share, but the point is communicated by simply saying hospitals that have a lot of Medicare and Medicaid patients and indigent care have an enability to cost shift to the private market. These institutions are obviously at risk on any kind of fixed add-on proposal on the Medicare side.

Third, hospitals across cities and across various geographic boundaries do not have the same rebuilding schemes.

There is a natural order of things and everybody is not at the same point in terms of rebuilding. As a result, you find that certain cities, particularly in the Northeast and Midwest, tend to be older in terms of their capital structure and need to be rebuilt more quickly in terms of the hospital component.

Finally, Mr. Chairman, our last point is simply this: There is no public good served by a policy or proposal that overpays some hospitals and underpays others. Such a proposal is indifferent to need. When you deal with proposals of that variety, Mr. Chairman, you are dealing, I submit, with random windfall and random risk.

Thank you very much, Mr. Chairman.

Chairman STARK. Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF THE GREATER NEW YORK HOSPITAL ASSOCIATION

Presented by:

Kenneth E. Raske, President
Greater New York Hospital Association

and

Daniel J. Rinaldi, Treasurer
Catholic Medical Center of Brooklyn and Queens, Inc.

Mr. Chairman and members of the Committee, thank you for the opportunity to present testimony today on a subject of critical interest and importance to hospitals in New York City, Medicare capital reimbursement policy.

I am Kenneth E. Raske, President of the Greater New York Hospital Association, a metropolitan hospital association that represents 68 voluntary hospitals and other health facilities in New York City and nearby communities. I am here today with Daniel J. Rinaldi, Treasurer of the Catholic Medical Center of Brooklyn and Queens, Inc., a multi-hospital system consisting of five hospitals located in New York City.

The purpose of this presentation is to discuss in real life terms the implications of an artificially low, flat rate add-on for capital payments to urban hospitals. This presentation will consist of two parts. The first part will examine the specific circumstances of the Catholic Medical Center, which is representative of many hospitals in New York City in terms of population served, services rendered and the need to keep pace with requirements of health care delivery. The second portion of the presentation will be devoted to a discussion of values that GNYHA believes are important in determining the efficacy of any capital reimbursement plan to be included in the Medicare Prospective Payment System.

THE CASE AT CATHOLIC MEDICAL CENTER

The Catholic Medical Center of Brooklyn and Queens, Inc. (CMC) consists of five hospitals that share the characteristics of many hospitals in New York City and other major urban areas serving significant numbers of poor, disadvantaged and elderly people. CMC provides primary medical care services to many who have nowhere else but the hospitals to turn. Medicare represents forty percent and Medicaid thirty percent of CMC's

patients. CMC's commitment is to meet the health care needs of the communities that the hospitals serve and to continually improve the delivery system. CMC's capital investment decisions have been made based on these goals. In 1985, capital, interest and depreciation expenses for CMC were 13% of total operating expenses. A reduction in current capital payment levels will be disastrous for CMC. The investments have already been made, these costs are fixed and there is little that can be done now to bring down these costs. CMC has made attempts to refinance existing debt in order to reduce interest expenses, however the tax exempt market is at a standstill. I would like to describe some of the capital investment decisions at each of CMC's hospital divisions:

The Mary Immaculate Hospital has 261 beds and provides an estimated 43,000 outpatient and 41,000 emergency service visits annually. This hospital is located in the economically depressed area of South Jamaica and was built in the early 1930s. Due to total plant deterioration and antiquated facilities, a modernization program was undertaken and completed in early 1984. This modernization did not add beds but rather brought the facilities and programs up to the required levels of quality. This project was combined with renovation at St. John's Queens Hospital for a total cost of $120 million dollars. It was financed through the FHA 242 program and the New York State Medical Care Facilities Finance Agency. CMC went through all the HSA and HUD requirements with the Federal government being the guarantors of payment. It is problematic that the Federal government can propose to so radically change capital policy as to reduce support to the capital projects that it had originally approved and financed.

The St. Mary's Hospital of Brooklyn (270 beds) is considered a financially distressed hospital by the State of New York and is located in Bedford-Stuyvesant, also an economically depressed community. The hospital was rebuilt in 1979 for a total cost of $35 million. The original hospital facility dates back to the early 1900s. This hospital is the only source of primary care medicine for many people in the area, providing 35,000 outpatient visits annually and several community outreach programs.

For the past 15 years, including 1985, CMC broke even. Therefore, any deterioration in revenue will severely impact CMC's ability to render services. CMC cannot change the existing debt service levels created by the renovation and modernization programs so clearly required for providing quality health care. There was certainly no opportunity for CMC to generate any surplus from existing cost based capital reimbursement. If capital

payments deteriorate, CMC will need to dramatically cut programs, particularly outreach programs and dental clinics. These are clearly needed as they serve to substitute for the lack of available physicians and dentists serving the area.

As for the future, access to capital for renovation, modernization or program changes to meet future needs will be severely limited if CMC's capital reimbursement shrinks. In New York City, this will surely result in a slowdown in the investment in new capital in underserved areas where there are tremendous physical plant and tehnological limitations.

The St. Joseph's Hospital, a 231 bed facility, built in the early 1950s, has a proposed $40 million modernization project. This hospital is in desperate need of renovation. The project includes a reduction of 32 beds. CMC is also looking to convert the Hospital of the Holy Family (83 beds) to a Skilled Nursing Facility and add sorely needed outpatient services for the community in downtown Brooklyn.

VALUES FOR CAPITAL POLICY

What can be learned from this case? GNYHA believes that it contains lessons concerning values that should guide Medicare's capital reimbursement policy. These are as follows:

Value #1: Hospitals that are engaged in or plan to undertake capital projects that will reduce capacity should be fully supported. "Downsizing" is consistent with national goals for the hospital industry and capital policies should not inhibit progress in this area. In New York City, hospitals are currently experiencing an 85% occupancy rate, which is well above the national average. However, local projections developed by the New York City Health Systems Agency indicate that there will be approximately 18% excess capacity by 1990. This excess capacity coupled with the current capital needs of many of New York City's facilities calls for rebuilding the hospital system at a "four-fifths" scale.

Value #2: Special attention must be paid to the capital needs of hospitals that serve a large number of Medicare and Medicaid beneficiaries and medically indigent persons. Hospitals in this category are disproportionately reliant on revenue from public sources and are not able to shift costs to other payers. Thus, the capital component of Medicare is crucial in maintaining their plants and equipment.

Value #3: Capital reimbursement must be adequate in order to give hospitals the necessary access to capital financing markets. An adequate and predictable reimbursement stream will assure financing at the lowest possible interest rates. This is a cost effective policy. Inadequate reimbursement creates risk and uncertainty that translates into higher cost borrowing.

Value #4: Capital policy should recognize that the capital needs of hospitals across the country are not identical at any given point in time. As a general rule, the more established American cities like New York have older hospitals and, thus, greater demand. According to data published by the United Hospital Fund of New York, the depreciation of the physical plant relative to its original cost is a measure of the age of the plant. In 1982, this was 45% for voluntary hospitals in New York City and 35% for hospitals nationally. The following table is an estimation of the average age (in years) of hospitals in New York City and nationally.

AVERAGE AGE OF HOSPITALS
New York City and U.S.

	N.Y.C.	U.S.
1981	10.8 years	8.6 years
1984	10 years	7 years

Source: United Hospital Fund of New York

Clearly, federal capital policy must take into consideration the variation in ages of hospitals.

Value #5: Federal capital policy should support increased efficiency. A major problem with a flat add-on to PPS prices for capital is that it may both encourage and permit hospitals that should close, because of under-utilization,

to remain open. Such facilities may not have major capital needs and, therefore, will use the capital add-on to subsidize operating expenses. Under this scenario, it is conceivable that a truly unneeded facility could remain open for 10-30 years, a result that is clearly inefficient.

Value #6: Capital reimbursement should be tied to need. Providing all facilities with a flat add-on results in under-capitalization of some and over-capitalization of others. This approach does not serve the best interests of hospitals or their patients.

CONCLUSION

GNYHA believes that the Administration's proposal for capital reimbursement falls short of meeting each of these values. In the final analysis, there is no public purpose to overpaying some hospitals and underpaying others, or adopting a system that provides counter-incentives to efficiency. Additionally, the proposal ignores the needs of hospitals with particular dependence on public funds. This could lead to a compromised health care system for Medicare beneficiaries.

GNYHA would be pleased to work with members of the Committee to further analyze the Administration's proposal or others and to assist in developing a rational alternative that meets true policy objectives.

Thank you.

THE FINANCIAL CONDITION OF NEW YORK CITY VOLUNTARY HOSPITALS: THE FIRST YEAR OF NYPHRM

United Hospital Fund of New York

December 1985

This paper was written by Susan Neshitt, Ph.D., and Melvin Krasner, Ph.D. The authors wish to acknowledge the special contribution of Scott Lewis of the United Hospital Fund and the assistance of Bruce C. Vladeck, David A. Gould, Emily Goodwin, and Madeline Sinisi, also of the Fund, and Charles Brecher of New York University. Useful comments and suggestions were made by the members of the Advisory Committee on Health Economics and Hospital Finance: Irwin Birnbaum, Joseph P. Corcoran, John F. X. Lovett, Edward Messier, Nora Piore, and Raymond D. Sweeney.

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United Hospital Fund Of New York

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United Hospital Fund Of New York

HIGHLIGHTS OF THE STUDY

- In 1983, for the first time since 1977, the average voluntary hospital in New York City did not incur a deficit.

- Nevertheless, voluntary hospitals in New York City continued to have a lower return on their assets than voluntary hospitals in the rest of the state, in the Mid-Atlantic region, and in the nation.

- New York City voluntary hospitals would need 85 percent of their total assets to repay their debt, while the comparison groups would use less than 60 percent.

- The annual rate of growth in hospital expenses among New York City voluntary hospitals declined from almost 12 percent between 1981 and 1982 to less than 9.5 percent between 1982 and 1983, which also was almost a full percentage point below the national rate of increase.

- Between 1982 and 1983, the value of uncompensated care provided by New York City voluntary hospitals increased from 3.4 percent to 3.7 percent of total operating expenses.

- Fourteen of the 49 New York City voluntary hospitals studied were financially stressed in 1983, compared to 18 in 1982.

- Without the additional revenues received from the NYPHEM pools, 10 more New York City voluntary hospitals would have had bottom-line deficits.

More details on the financial condition of New York City voluntary hospitals in 1983, the first year of NYPHEM, follow. Definitions, data sources, and methods are described in an appendix to the report, which also includes a glossary of financial terms.

INTRODUCTION

Since the late 1970's, the financial condition of voluntary hospitals in New York City has been profoundly influenced by the reimbursement methods developed by the State Department of Health. The reimbursement system, the most stringent in the country, was put into place in an effort to control hospital costs that had increased dramatically since the introduction of the Medicare and Medicaid programs in 1965; unfortunately, it created severe financial stress for many of the city's voluntary hospitals. Many institutions were forced to close, while others survived only through extraordinary governmental and community intervention. It also became apparent that even hospitals that did not face the danger of imminent financial collapse were being forced to operate in ways that threatened their long-range financial viability.

In response to these pressures, the state developed and, in 1983, implemented the New York Prospective Hospital Reimbursement Methodology (NYPHRM). Its introduction brought several important changes for hospital reimbursement in New York State. First, payment for patients covered by Medicare, which had previously been based on a retrospective examination of costs, was, through a Federal waiver, to be made on the basis of the general principles of per diem, prospective reimbursement that applied to patients covered by Medicaid and Blue Cross. Second, a host of reimbursement rules to discourage increases in hospital expenses were implemented, refined, or strengthened. Finally, while maintaining incentives to control expenditures, NYPHRM also included several specific provisions to alleviate hospitals' financial stress, among them the establishment of four separate pools of funds, aimed in particular at those hospitals serving disadvantaged communities and the uninsured.

The experience of NYPHRM's first year of operation, 1983, provides the first real-world test of the state's strategy in balancing concerns about aggregate hospital costs and hospitals' financial viability. Although caution is necessary in generalizing from a single year's experience, an analysis of hospitals' financial performance in 1983 reveals some rather clear signs of what NYPHRM accomplished and which of its elements ought to be preserved and strengthened as the state explores new approaches to hospital financing.

IMPROVEMENT IN FINANCIAL CONDITION

NYPHRM, in its first year, clearly alleviated a great deal of the hospitals' financial stress. For the first time since 1977, the average (median) voluntary hospital in New York City did not incur a deficit. Similarly, the growth in hospitals' indebtedness slowed in 1983, and the amount of liquid assets available to meet hospitals' short-term obligations increased.

Without doubt, much of the improvement in the hospitals' financial situation can be attributed to the infusion into the hospital system of new revenues in the form of the NYPHRM pools, the largest of which is designed to defray the costs of providing care that would otherwise remain uncompensated. NYPHRM, however, also significantly strengthened existing incentives to contain hospital costs, and this too appears to have contributed substantially to hospitals' improved fiscal health.

Prospective payment, which, under NYPHRM, encompasses Medicare as well as Medicaid and Blue Cross, severs the direct link between hospital revenues and hospital expenses that exists under cost-based, retrospective reimbursement. Thus, prospective reimbursement provides hospitals with a real opportunity to improve their financial situation by controlling expenses. In fact, the annual rate of growth in hospital expenses among New York City voluntary hospitals declined from almost 12 percent between 1981 and 1982 to less than 9.5 percent between 1982 and 1983, which also was almost a full percentage point below the national rate of increase. From society's perspective (and that of the third-party payers), the concomitant increase in the rate of growth in hospital revenues between 1982 and 1983, which represents an increase in society's outlay for hospital services, engenders some concern. Nevertheless, the slowing in the rate of increase in expenses at individual hospitals bodes well for the long-term trend in aggregate expenditures for hospital services.

The amount of uncompensated care provided to indigent patients also increased in 1983. NYPHRM makes specific provisions for defraying the costs of such care, so that the increase was not completely unexpected. It is, however, comforting to know that the improvement in hospitals' financial condition was not achieved at the expense of uninsured patients.

INDICATORS OF FINANCIAL CONDITION

Because a hospital's financial condition is related to a combination of short-term and long-term factors and to both its resources and obligations, several financial measures must be used to obtain a reliable assessment of financial condition. Four fundamental dimensions of financial condition are utilized in this report: annual operating results, long-run solvency, age of plant, and liquidity.

Annual Operating Results

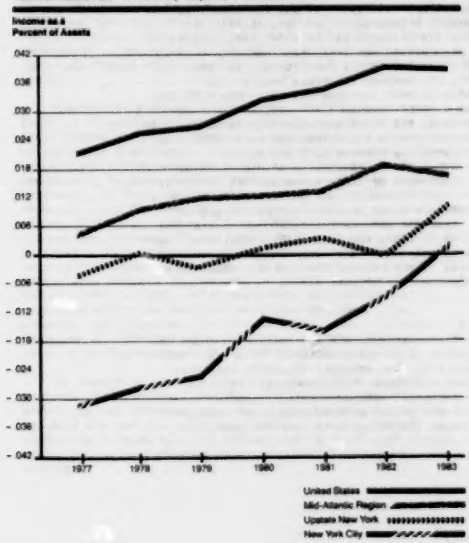
For a hospital to be in good financial health its annual income should exceed its annual expenses. Otherwise, it will be forced to borrow from its reserves in the short run, will be unable to meet its expenses in the long term, and will clearly be unable to expand or modernize its facilities. In 1983, the first year of NYPHRM, the average voluntary hospital in New York City was able to meet its expenses, but only with the addition of revenues derived from philanthropy, income from bequests and investments, and other non-operating income. This was a marked improvement over the previous six years when even the addition of non-operating revenue left the average voluntary hospital with deficits ranging up to 3 percent of hospital expenses. Although, by these measures, New York City hospitals' financial condition still was substantially weaker than that of hospitals elsewhere in the country, the gap had narrowed somewhat. Nevertheless, as the return on assets just barely turned positive in 1983, the financial condition of the average voluntary hospital in New York City sharply contrasted with that of hospitals in the rest of the country, whose return on assets approached 4 percent (Figure 1).

Long-Run Solvency

A hospital's level of indebtedness and its ability to repay its debts are key indicators of fiscal condition. Although a lower level of debt usually indicates stronger financial condition, if a hospital can meet additional loan payments, the level of indebtedness can be increased without harming financial solvency. Thus, both the extent of indebtedness of a hospital and the ability to repay the obligations must be considered.

When expressed as a percentage of total assets, the level of indebtedness indicates the share of all assets required to pay off all debt (Figure 2). Since 1977, the average voluntary hospital in New York City has had a much higher level of debt than any of the comparison groups (voluntary hospitals in the rest of the state, in the region, and in the nation), and, until 1983, the difference between New York City and the other groups had been growing. The percentage of assets required to

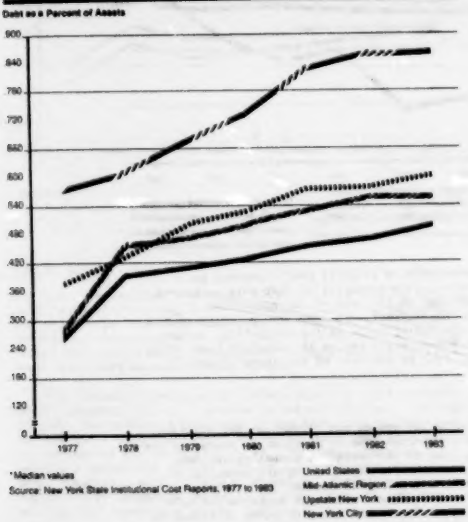
Figure 1
Return on Assets Ratio* for Voluntary Hospitals, 1977 to 1983



pay the debt in New York City increased from 57 percent in 1977 to 85 percent in 1982, but decreased somewhat between 1982 and 1983. Thus, in 1983, the first year of NYPHRM, the distance between New York City hospitals and the comparison groups decreased slightly.

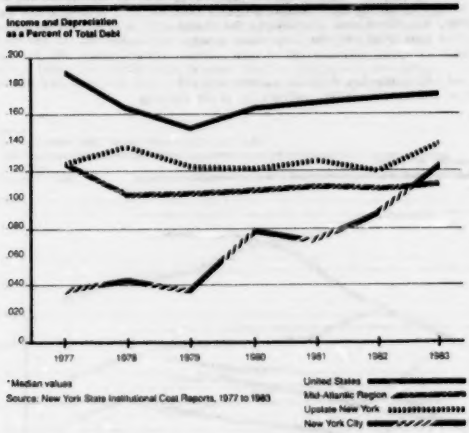
Between 1977 and 1983, the New York City voluntary hospitals' cash flow relative to debt, reflecting their ability

Figure 2
Debt Ratio* for Voluntary Hospitals, 1977 to 1983



*Median values
Source: New York State Institutional Cost Reports, 1977 to 1983

Figure 3
Cash Flow to Debt Ratio* for Voluntary Hospitals, 1977 to 1983



*Median values
Source: New York State Institutional Cost Reports, 1977 to 1983

to repay debt, increased from slightly over 3 percent to a little over 12 percent, with a quarter of that gain occurring in 1983.* The cash flow in the rest of the state also increased in 1983. In contrast, the cash flow relative to debt has decreased for the Mid-Atlantic region since 1977, so that the figure for the Mid-Atlantic region is presently lower than that for either the city or the rest of the state (Figure 3).

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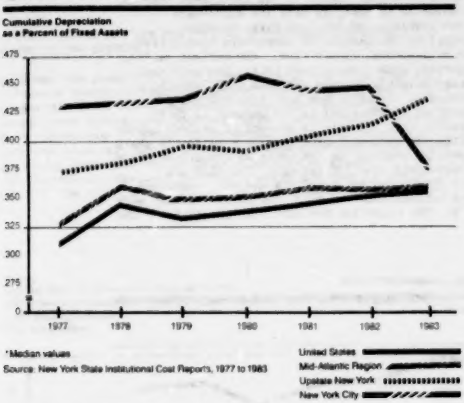
* Note: Cash flow is the sum of net income and depreciation. Depreciation is a non-cash expense intended to represent the value of assets used in the course of annual operations. Revenues allocated to cover depreciation are potentially available to repay borrowing for capital improvements. Thus, the combination of net income and depreciation is a frequently used measure of cash flow, or funds available to repay debt.

Figure 4
Age of Plant Ratio* for Voluntary Hospitals, 1977 to 1983



*Median values
Source: New York State Institutional Cost Reports, 1977 to 1983

Age of Plant

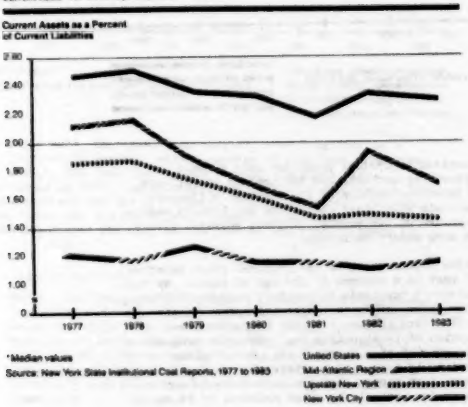
The age of a hospital's physical plant not only affects the efficiency of providing services and the comfort of patients, but also is an important measure of the hospital's financial condition. Hospitals with older facilities may have to borrow sooner for renovation or replacement of their physical plants than those with more modern buildings.

The cumulative depreciation of the physical plant relative to its original cost is a measure of the age of plant. By this measure, the voluntary hospitals in New York City in 1983 were, for the first time since 1977, in better shape than hospitals in the rest of the state (Figure 4). The improvement was largely a reflection of construction and renovation projects at seven hospitals, most of them in Brooklyn. Nevertheless, New York City hospitals appear to be older than the national and regional comparison groups, but the difference is not nearly as large as for some of the other measures of financial condition.

Liquidity

A hospital in sound financial condition has sufficient cash, or assets easily converted to cash, to meet its short-term obligations. The liquidity of New York City voluntary hospitals, measured by the percent of short-term liabilities that can be met with current assets (i.e., the current ratio), or, more stringently, with cash on hand (i.e., the acid test ratio), has varied slightly between 1977 and 1983, showing a small decline overall. In 1983, New York City voluntary hospitals had current assets equal to 114 percent of their current liabilities; that is, only 14 percent of current assets would remain after all current liabilities were paid. In sharp contrast, the average hospital in the national comparison group had a current ratio well over 200 percent. The distance between New York City voluntary hospitals and the comparison groups decreased between 1982 and 1983, but still remained very large (Figure 5). The trend for New York City hospitals in the

Figure 5
Current Ratio* for Voluntary Hospitals, 1977 to 1983



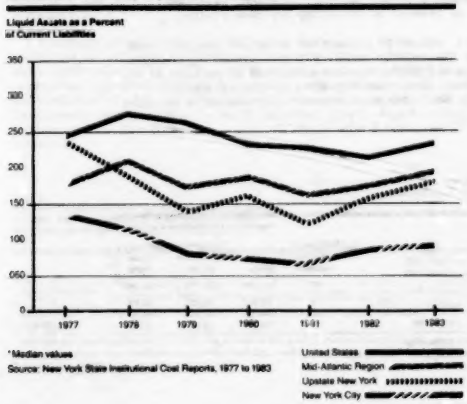
*Median values
Source: New York State Institutional Cost Reports, 1977 to 1983

acid test ratio, the more stringent measure, followed a similar pattern (Figure 6).

TO WHAT EXTENT ARE THE NEW YORK CITY VOLUNTARY HOSPITALS EXPERIENCING STRESS?

Although the general financial condition of New York City voluntary hospitals improved between 1982 and 1983, the financial condition of individual hospitals remains a significant concern and requires careful monitoring. Using the four dimensions discussed above--annual operating results, long-run solvency, age of plant, and liquidity--New York City's voluntary hospitals can be arrayed into three groups: (1) financially stressed hospitals, which are weak in two or more of the dimensions; (2) hospitals with warning signs, which

Figure 6
Acid Test Ratio* for Voluntary Hospitals, 1977 to 1983



*Median values
Source: New York State Institutional Cost Reports, 1977 to 1983

are weak in one dimension; and (3) financially healthy hospitals, which are comparatively strong in all four dimensions (Table 1).

- Financially Stressed Hospitals. Of the 49 New York City voluntary hospitals included in this study, 14, or 29 percent, had multiple financial problems in 1983. These hospitals accounted for 21 percent of the beds in voluntary hospitals and almost 24 percent of the outpatient department and emergency room visits.

- Hospitals with Financial Warning Signs. These 18 hospitals, or 37 percent of the total, with financial warning signs in 1983 accounted for about 44 percent of New York City's voluntary hospital beds. They provided over 41 percent of the total outpatient department visits and more than 48 percent of the total emergency room visits.

- Financially Healthy Hospitals. Seventeen of New York City's voluntary hospitals, or nearly 35 percent of the total, showed no signs of distress. In 1983, almost 35 percent of the total beds were located in these hospitals, which provided 35 percent of the outpatient department visits and 27 percent of the emergency room visits.

In the Bronx, almost 50 percent of voluntary hospital beds were located in financially stressed institutions; in Brooklyn, financially stressed facilities accounted for 40 percent of the beds. In contrast, less than 9 percent of the voluntary hospital beds in Manhattan were located in financially stressed institutions.

Table 1
Incidence Of Financial Stress
Among New York City Voluntary Hospitals
1983

Financial Condition	Number of Voluntary Hospitals	Percent of All Voluntary Hospitals: Beds	Outpatient Department Visits	Emergency Room Visits
All Hospitals	49	100.0%*	100.0%	100.0%
Financially Stressed	14	20.99	23.73	23.98
Warning Sign of Stress	18	44.39	41.30	48.70
Relatively Healthy	17	34.61	35.07	27.42

*Numbers may not add due to rounding.
Source: New York State Institutional Cost Reports, 1983

Of the 14 hospitals fiscally stressed in 1983, 12 of them had also been stressed in 1982; the other two had financial warning signs. Three hospitals had been continuously stressed since 1977, while one hospital had been stressed in all but one of those years. Four hospitals that had been stressed in 1982 were no longer stressed in 1983, but they did not achieve full financial health.

IMPACT OF THE NYPHRM POOLS

As mentioned, four separate pools of funds were established to provide financial support for hospitals for a variety of reasons. The largest of the pools, accounting for over half of total pool funds, was the Bad Debt and Charity Care Pool (see p. 17). In 1983, each hospital also received a Discretionary Allowance to help retire short-term debt or otherwise improve the hospital's financial situation; in subsequent years, distribution from this pool would be at the discretion of the Commissioner of Health. The other two pools were a Transition Fund targeted to hospitals adversely affected by the inclusion of Medicare in NYPHRM, and a Distressed Hospital Pool to alleviate the severe financial stress of hospitals serving poor communities.

The most direct effect of NYPHRM on hospitals' financial condition undoubtedly was through the pools. The infusion of about $200 million in additional funds to hospitals statewide (excluding the Discretionary Allowance), with approximately $100 million of that going to voluntary hospitals in New York City, could hardly result in anything other than a significant improvement in the financial health of the hospital industry (Table 2).

Table 2
Revenues Received by New York City Voluntary Hospitals from Bad Debt and Charity Care Pool, Transition Fund, and Distressed Hospital Pool
1983

	New York City Pool Revenues
Voluntary Hospitals	$83,084,261*
Proprietary Hospitals	1,182,983
Public Hospitals	20,814,199

*This total excludes three specialty hospitals, not included in the analysis, that received $1,359,865, and includes the distributed for one facility outside New York City, which is in a multi-hospital system.
Source: Office of Health Systems Management, 1983

Table 3
Effect of New York Prospective Hospital Reimbursement Methodology on Selected Financial Ratios*
for New York City Voluntary Hospitals
1982 and 1983

	1982	1983		
		With Pools	Without Pools	With a 2% Increase for All Hospitals
Number of Hospitals				
With Bottom-Line Surpluses	10	25	16	24
With Bottom-Line Losses	38	22	32	24
Breakeven	1	2	1	1
Median Ratio				
Return on Assets	-.009	.006	-.009	-.002
Total Margin	-.200	.001	-.036	-.003
Cash Flow to Debt	.088	.123	.065	.071

*Median Value
Source: New York State Institutional Cost Report, 1982 and 1983
Office of Health Systems Management, 1983

As shown in Table 3, 38 hospitals were unable to meet their expenses in 1982, even with the addition of non-operating revenues from endowments, contributions, and other sources. In 1983, however, the number of hospitals that incurred bottom-line deficits decreased to 22. In fact, more than half of the hospitals had surpluses in that year. The effects of the NYPHRM pools were substantial, as an additional 10 hospitals would have had deficits if the pool money were excluded from their income statements.

Interestingly, however, the specific method used to allocate the pool funds, which appears to have been carefully crafted to deal with the complexities of hospital economics and equity goals, did not seem to make much of a difference: Only two additional hospitals would have experienced a deficit if the pool money were distributed simply as a 2 percent add-on to the revenue of each hospital. This result should not be totally unexpected, since the major pool compensated hospitals for bad debt and charity care, and hospitals with surpluses provided proportionately as much of this care as did hospitals with deficits. In a recent report, Goodwin reported that on average 7 percent of net patient service revenues at hospitals with surpluses represented bad debt and charity care, compared

to 4.7 percent at hospitals with deficits.* Thus, the distribution of funds based on the provision of care to the uninsured will not necessarily lead to the greatest reduction in the number of hospitals incurring deficits.**

The data also suggest that some hospitals would have been financially healthier in 1983 than in 1982 even without the addition of money from the NYPHRM pools: Only 32 hospitals would have incurred a bottom-line loss in 1983 after the subtraction of the NYPHRM pool funds, compared to 38 hospitals with deficits in 1982. Although many different factors may have caused this improvement in financial health, there is a strong indication that the strengthening of the prospective payment method under NYPHRM contributed to this improvement. The fact that all three major third-party payers were now subject to the same set of prospective reimbursement principles provided the hospitals with a set of unambiguous incentives regarding cost. Furthermore, as compared to the pre-NYPHRM period, these incentives were solidified by ignoring individual hospitals' cost experiences after 1981 in the setting of payment rates for the period through 1985. Nevertheless, some hospitals would have been in worse financial shape in 1983 than in 1982 if not for the pools, as the median value for return on assets and the ratio of cash flow to debt would have decreased somewhat.

Bad Debt and Charity Care

The provision of care to patients who are uninsured and who do not have the financial resources to pay for it is a mission characteristic of virtually all voluntary hospitals in the city. There is no doubt, however, that the volume of charity

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* Emily J. Goodwin, "Uncompensated Care and Its Relationship to the Financial Condition of Hospitals," in Hospitals and the Uninsured Poor (New York: United Hospital Fund, 1985), 77.

** For an analysis of alternative approaches to distributing funds to support hospitals' community service, see Dina Keller Moss, Emily J. Goodwin, and Bruce C. Vladeck, "Financing Hospital Charity Care: An Analysis of Alternative Methods for Distributing Funds," United Hospital Fund, Paper Series 3, in press.

care varies widely among the hospitals, and that their financial ability to provide such care has been constrained by the fiscal austerity accompanying the stringent reimbursement system that had been put into effect in New York a decade ago.

The Bad Debt and Charity Care Pool, a central feature of NYPHRM, acknowledged the importance of the charity care provided by New York City's voluntary hospitals and the tremendous financial burden it imposes on these institutions. The pool for 1983, however, was distributed to hospitals not on the basis of the charity care provided in that year, but on the basis of such care provided in 1981. The volume of charity care provided in 1983 would not have an impact on a hospital's distribution from the pool until 1985. More importantly, because the aggregate amount available for distribution to all hospitals would be a fixed proportion of aggregate hospital revenue, there was substantial uncertainty about the percentage of bad debt and charity care cost that would actually be reimbursed. Thus, the existence of the pool would not necessarily be expected to lead directly to an increase in the amount of bad debt and charity care provided by hospitals.

The data, nevertheless, show an increase in 1983 in the dollar value of the uncompensated care* provided by the city's voluntary hospitals. In 1982, the cost of uncompensated care was approximately $173 million, almost equally divided between inpatient and ambulatory care. By 1983, this figure increased to $224 million, of which $117 million represented ambulatory care. The cost of bad debt and charity care constituted 3.7 percent of total operating expenses at the average hospital in 1983 compared to 3.4 percent in 1982, an indication that there was a real increase in the volume of uncompensated services. Clearly, then, the improvement in the voluntary hospitals' financial situation in 1983 was not achieved by curtailing services to the uninsured poor, but more likely reflected an across-the-board curtailment in hospital expenses induced by

* This measure of bad debt and charity care was developed as part of NYPHRM. It is a very conservative measure in which inpatient bad debt and charity care is reduced to cost while ambulatory bad debt and charity care is often below cost. Median values were used. The mean in 1983 was 5.2 percent while in 1982 it was 4.3 percent.

the clear-cut incentives under NYPHRM and the added revenue from the pools.

CONCLUSION

The first year of NYPHRM clearly indicated that creative approaches to hospital financing can make a difference. The new payment system apparently succeeded in alleviating the most severe financial stresses on voluntary hospitals, without sacrificing cost containment goals. Nevertheless, on the basis of several important financial indicators, hospitals in New York City continued to appear disadvantaged relative to hospitals in the rest of the nation. More importantly, fully two-thirds of the voluntary hospitals in New York City were either financially stressed or experiencing financial warning signs in 1983.

Of particular concern is that hospitals located in economically disadvantaged areas continue to exhibit signs of substantial financial stress. While NYPHRM was clearly designed with the problems of these institutions in mind, it is obvious that the reasons for financial distress are not easily identified or addressed. Bad debt and charity care, though a very important factor, is only one of many complex variables associated with hospital deficits. Until we gain a much better understanding of hospitals' financial performance, it will be very difficult to balance the competing objectives of cost containment, financial viability of hospitals, and access to care for the uninsured poor. Accordingly, the United Hospital Fund is now conducting a sophisticated, multivariate analysis of hospitals' finances and the effects of such variables as hospital location, teaching activity, and case mix.

Whether the early results of NYPHRM truly represent the capabilities of this reimbursement system will become clearer as data for 1984 and 1985 are assembled and analyzed. The experience under NYPHRM II, beginning in 1986, should further test the basic reimbursement principles implemented in 1983. For, under NYPHRM II, although Medicare will follow the Federal Prospective Payment System's per-case reimbursement methods--in contrast to Blue Cross and Medicaid, which will continue per diem reimbursement--all three payers will be on a prospective basis.

NYPHRM II is only an interim payment system, and active discussions and analysis are underway of alternative systems to follow it. The insights regarding reimbursement principles provided by this first analysis of hospitals' financial status under NYPHRM and the forthcoming results of related analyses that involve modeling of hospitals' financial performance should provide a sound empirical and analytical basis for developing and refining a reimbursement system that can address the complexity of objectives surrounding hospital financing in New York State.

DEFINITIONS, DATA SOURCES, AND METHODS

The Research

This United Hospital Fund Paper is based upon research conducted at the United Hospital Fund by Susan Meshitt. Dr. Meshitt is Financial Analysis Manager at the Fund.

Criteria for Determining Financial Stress

The classification of hospitals according to their degree of financial stress is based on multi-dimensional analysis of hospital financial condition developed by Dr. Charles Brecher and Dr. Meshitt. For two of the indicators, a weak position was linked to absolute values. For the other two indicators, a weak position was determined based on the distribution of values for voluntary hospitals in upstate New York; that is, the 90th percentile for upstate voluntary hospitals was set as the criterion. Specifically, the following criteria were used to identify hospitals in a weak position:

Annual Operating Results. Among New York City voluntary hospitals, 19 suffered annual operating losses in 1983. However, 13 of these 19 hospitals did not actually have to convert part of their assets to cash to cover operating expenses because their loss was less than their annual depreciation expense. Since depreciation is an accounting entry but not an actual cash outlay, the loss was in effect covered by not setting aside funds to replace an aging plant. Thus, six of the city's voluntary hospitals suffered actual cash losses (i.e., had a negative cash flow). These institutions were designated as weak in their annual operating results. The same criteria were used to identify hospitals weak on this dimension in earlier years.

Long-Run Solvency. In 1983, only 18 percent of voluntary hospitals in upstate New York had debts which exceeded 85 percent of their assets. This relatively extreme point was set as the criterion for designating a hospital as being weak on this indicator. Among New York City's voluntary hospitals, 24 institutions were this heavily indebted in 1983.

Age of Plant. In 1983, only 10 percent of voluntary hospitals in upstate New York had permitted more than 55 percent of their fixed assets (excluding land) to be depreciated. Accordingly, this relatively extreme condition (i.e., an age of plant ratio above .55) was used to designate a hospital as weak on this indicator. Among New York City's 49 voluntary hospitals, nine had such aged plants in 1983.

Liquidity. Inability to meet short-term obligations with liquid assets is evidenced by a current ratio of less than one, and this criterion was used to identify hospitals in a weak position. Among New York City's 49 voluntary hospitals, 17 fell into this category in 1983.

Sources of Data

Financial data for New York City and upstate New York hospitals for 1977 through 1983 were obtained from the Uniform Financial Reports (1977 and 1978) and the Institutional Cost Reports (1979, 1980, 1981, 1982, and 1983) filed by the hospitals. These reports are compiled by local Blue Cross/Blue Shield Associations and data from them are transferred to computer tapes that are furnished to the New York State Department of Health. Copies of these tapes were supplied to the authors by the Department. The tapes were edited by the authors, and updated material from Blue Cross/Blue Shield and the United Hospital Fund was added. In addition, for 1981 and 1982 the Hospital Association of New York State made available its edited version of the computer tape. The national and regional hospital financial data came from the annual survey conducted by the American Hospital Association and the Hospital Financial Management Association. Median values for the national ratios used in this report, except the acid test, were provided to the authors by the American Hospital Association's Hospital Data Center. The acid test ratio median value is from the Hospital Financial Management Association.

Glossary of Financial Terms

Current assets--Cash and other resources such as accounts receivable and inventories that can be converted into cash within a relatively short time.

Fixed assets--Buildings, property improvements, equipment, and similar assets that are not easily converted to cash.

Total assets--All resources (current and fixed) owned by the hospital.

Current liabilities--Obligations that have to be met within one year, such as accounts payable, taxes and salaries due, and short-term loans.

Long-term liabilities--All obligations that do not have to be met within one year, such as long-term loans, bonds, and mortgages.

Debt--All liabilities, current and long-term.

Net income--The difference between revenues and expenditures for a given year.

Depreciation--An annual non-cash expenditure estimated to reflect the value of fixed assets used in the course of producing services.

Cash flow--Net income plus depreciation.

Cumulative depreciation--The sum of all years' annual depreciation taken on fixed assets.

Historical cost of depreciable fixed assets--Original purchase price or construction cost of buildings, improvements, equipment, and similar assets against which depreciation has been charged.

Charity care--Inpatient bad debt and charity care reduced to cost plus the outpatient deficit less adjustments for government payors.

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Chairman STARK. Mr. Raske, isn't it true, once we get through this process of converting to some prospective system or DRG, at whatever point that is—probably in less than 20 years—is there any reason we shouldn't be able to bury this capital issue once and for all?

Other purchasers of your service, as we discussed earlier, don't pay you in two lumps; they pay you in one, and you don't break it out. You may account for capital, but we are the only purchaser who ever got into this two-track system.

So we are really dealing with how we get from one system to the other, and I think we are all aware that that isn't going to be easy.

There are going to be windfalls and so on. I don't think anybody has suggested, the administration, this committee or anybody else, that everybody will be happy. My theory is if there is anybody in the room smiling, we have done it improperly because they are the ones getting the windfall.

I don't see any hint that we would switch from proceeding toward this overall PPS. We may be doing a lot more adjusting to that system in future years than any of us anticipated. I sort of accept that as a given.

How do we get there from here is where we need the help.

Mr. Rushkoff's associates tempt me to suggest that Stanford's position is ready. All they have to do is raise their green fees on their lovely golf course and they could take care of any shortfall problem. I don't know that Sinai has that luxury. There are some institutions that probably can afford this.

I didn't ask Dr. Singleton; I presume that you, like the others, had started your planning for your expansion way before 1983, is that correct?

Mr. SINGLETON. That is correct.

Chairman STARK. So none of you had a chance to react to the law in 1983.

At what point does it seem reasonable—you know more about hospital planning collectively than the rest of us—that the committee should say to the hospitals, you should have known better?

Mr. RASKE. If I may, Mr. Chairman.

Chairman STARK. How far back do we go in history where the warnings of the 1983 legislation should have been sufficient so we don't have to hold harmless those people?

Mr. RASKE. I don't think the issue is a question necessarily of when but rather of how much, and that is the cost of making a transition like this.

I think the fundamental question, fundamental public policy question, has to be the cost of the transition. I don't mean necessarily in monetary terms alone. I mean in terms of the reshaping of the health care system, in the restructuring of the monetary as well as psychic costs that go along with it.

When you look at the transition costs, they are sizable. Who are the casualties in the process? We can name them now. You have your teaching centers; you have the institutions that tend to serve a disproportionate share of Medicare, Medicaid, and non-paying patients. They are a casualty. Perhaps some rural hospitals as well.

Chairman STARK. If I can stop you there, and I don't disagree but think you have it from the strange structure we operate here now.

This committee is charged with providing medical care to people over 65 basically. However, the idea of paying for teaching was something we inherited by default. It really doesn't relate. It is there in the law.

I don't disagree with you, but what I am saying is that any more than the disproportionate share side, the poor are taken care of by Medicaid for better, for worse, in whatever strange way the Government got there, and that really becomes a public assistance issue.

I think we would all agree that we don't provide adequate care for the underinsured, the uninsured, and that is as much probably the Government's fault as the industry's fault. The problem is that we are faced with the very real issue of a pressure to reduce our budget. How far that should go is a matter of great debate.

If you face that, and then face what Medicare is looking at and its trust fund, I will stipulate those things and not take a back seat to anyone who would love to spend some time on the normative issues of what we ought to be providing the people. That is a luxury we don't even come close to having.

Right now we are sitting on this subcommittee fighting a retreat and retreats are never fun whether it is on the sports field or the battlefield or here. But, frankly, that is what we are doing.

What we have to do here is figure out how much we can hold politically recognizing that some of the people who get windfalls are not going to support any rule that eliminates too much of that any more than we will get political support if we absolutely decimate your industry.

I wish we could do what is right. That is usually the best legislation. But we are faced with some pretty narrow constraints.

I assure you—well, I share your concern. Go ahead.

Mr. RASKE. The only point I have, Mr. Chairman, is in the process of figuring public policy alternatives. You recognize that this particular proposal has, if I may say, a double dip on retrenchment and simply put, you have the averaging effect which is one hit, depending on where you sit on that side of the average, and the second is the compression from the budgetary standpoint in terms of reductions that are forcing the average down.

So what these types of institutions that are at this table right now, which are many in terms of numbers and complexion, they see both of those impacts. Both of them are representing significant problems.

Chairman STARK. Let's ask the witnesses here.

You all represent people who are subject to getting big cuts. All of you here are looking at this administration's proposal as being a lot more horrendous than you thought.

What do we do to prohibit windfalls? Take these hospitals that are not very capital intensive and probably won't improve their fa

cilities, but will get a lot of money laid on their heads under this proposal. How do we eliminate that?

Mr. RUSHKOFF. Perhaps one idea, Mr. Chairman, is to take a portion of the percentile being suggested and put it aside for hospitals that do in fact have building programs and that can substantiate to someone that these funds are being expended for the purpose given.

Chairman STARK. In other words, not let them sit with this unfunded reserve and play with it, but we will hold it and they have to prove they need it or spend it?

Mr. RUSHKOFF. Or give it to the institutions that do in fact have major building programs. Very much like the outlier matter.

Dr. DUVAL. I think the suggestion was made earlier this afternoon, the closest you could get—you are correct there is no such thing as the answer for all of us, but the closest you can get is to weigh the institution-specific part of the formula much more heavily at the beginning in order to give it time to catch up.

Second, leave a long enough transition so it can accommodate by using operating funds to underwrite its capital obligations.

Chairman STARK. All right.

Mr. RUSHKOFF. There is another point that was alluded to but not really spoken to in depth. That is that hospitals, certainly of my coalition, will meet their budgets just as the Government must meet its budget, but what must be pulled out of the budget then to pay for the capital costs that are not going to be reimbursed becomes very serious.

We are the health care provider to east Harlem. We are their family doctor. We have some 30,000 people that come to our clinics.

We give approximately $15 million in free and charity care. We would have to cut into that budget for free care to stay alive, to pay off our amortization.

Chairman STARK. That is unreimbursed charitable care?

Mr. RUSHKOFF. Well, right now New York State has a special program where they reimburse a part of it, but under DRG's that is not recognized any longer.

Mr. RINALDI. Mr. Chairman, if I could, please, I am Mr. Rinaldi from the Catholic Medical Centers.

The point I really would like to make on this issue, I think as a group what we are asking for is really not to be penalized for things we have already done and quite frankly have very little control over at this particular point in time.

For example, the Catholic Medical Center, we have five facilities. We have rebuilt three of them. Unfortunately, we find ourselves in a situation where our capital expense is 13 percent of our total expenditures.

I think what we are really asking for is, and the point was made earlier, that if it is going to be prospective, then let us deal with this in projects that we will commit to in the future, not for something that, unfortunately, we have already committed ourselves to. I think that is the basic point we are trying to make.

Chairman STARK. Where are these guys who get the average down to 7 percent? With everybody it has been 18, 13.

Mr. RINALDI. I don't think they are in the inner cities to say the least.

Chairman STARK. Mr. Gradison is suggesting that the public hospitals in the inner cities have not rebuilt, so they just don't have capital costs.

Well, I thank the panel for their patience.

There is one more question. I have said that I anticipate this flat capital will fold in with what is coming down the track, and we may not be able to change that. So we are looking at transitions and adjustments and so on in rates that may minimize it all.

But is there an inherent flaw in that system? Is there something that you see that that system by itself, the idea of taking this capital and putting it into where I presume the other non-Medicare payments that you receive you don't get separate capital.

Are we doing something that will really dislocate the system or do harm to the overall Medicare delivery system by completely removing capital reimbursement on a cost basis?

Does anyone want to comment on that?

Mr. RASKE. I think, Mr. Chairman, the answer is with design of any of these national systems is the impact it has on specific instances. Clearly you could take, for example, a certain percentage reduction of PPS payments across the board and achieve the same kind of dollar savings that you are forecasting for this particular provision. The difference is the distribution of those payments and the public policy tone.

The issue before this committee, hopefully, is the question of the proportionality or disproportionality of the hit, and is that consistent with good public policy, admitting that Medicare is only a segment of the public policy arena as it relates to paying for services.

And what we are submitting is that given the nature of the institutions involved here—institutions that serve a lot of public patients, institutions which serve as teaching vehicles, for regeneration of human capital, which are generally meritorious values—we submit those are not good ways of going about compressing payments.

So to answer your question, I would feel the answer is that we ought to keep on searching for other kinds of vehicles to do a better job, because the current one does not do the job.

Chairman STARK. I would ask, just in conclusion, that if any of you could submit the same sorts of "what-if" scenarios that we asked the gentleman from Cincinnati to submit, it would be appreciated. For example, what if your DRG rates would increase at the rate of 2 or 3 percent and indirect teaching would increase at 11 and go up rather than drop to 8 percent, and are there scenarios other than going to a 20-year phase-in, or could we go to a 7-year phase in? Can any of you anticipate a scenario like that that would come close to solving the problems you see ahead that may be an approach that we could consider?

If stretching the phase-in period isn't enough, we will have to look at other things. Having 6,000 transition rules, one of them for each hospital, which is another alternative, we will have to look to something because that won't work. I would like to start with the hospitals that are severely impacted and worry last about what we do to resolve the windfall hospital question. So any of that which you care to submit would be very useful.

Mr. RINALDI. I know you raised that point, Mr. Chairman, several times today and to my way of thinking, I guess if the base stays consistent such as 1983, it is hard for me to envision how any type of stretching it out will make up for the shortfall.

On the other hand, if it is a facility that is making money or will offset it through some profits, for example, the majority of hospitals in the city and State of New York really don't have that capability.

So off the top of my head, it would seem that that shortfall can only be made up through some sort of profits or, as you noted earlier, some cost-shifting or charging other sectors. But I think that would be extremely difficult.

For example, in our case, it would be difficult to make up a Medicare shortfall of $5 or $6 million no matter how long a period it is stretched out. I think certainly some of the newer projects that are already in the pipeline, I think the scenario would be worse.

Perhaps Marvin would want to comment on that.

But it is hard to envision, really, a way of catching up without getting it from profits.

Mr. RUSHKOFF. If we started the 7 years in 1985, it would be over by 1992 and our program comes into effect in 1991 so we would have 1 year of a phase-in. With these long projects, these major rebuildings, it is quite a problem to come up with a long enough phase-in period.

Chairman STARK. If the administration's proposal became law, what would you do?

Mr. RINALDI. We would curtail services.

Mr. RUSHKOFF. We would have to reduce our charity care and curtail services and new programs.

Chairman STARK. Or get paid for it.

Dr. DUVAL. Yes.

Mr. RUSHKOFF. Yes.

Chairman STARK. Thank you.

As we usually do, saving the best for last, we will now hear from a panel made up of the Federation of American Health Systems, represented by Mr. Bromberg; the Healthcare Financial Management Association, represented by Mr. Kuchler; Healthcare Financing Study Group, represented by Francis Byrnes; and the American Health Planning Association, represented by Mr. Abernethy.

STATEMENT OF MICHAEL BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HEALTH SYSTEMS

Mr. BROMBERG. Thank you very much, Mr. Chairman.

This is the first time we have had a chance to testify under our new name, American Health Systems, and I want to thank you for letting us have that opportunity.

I would like to make a couple points in brief in the beginning to respond to some of the questions and I would first submit the statement for the record.

Chairman STARK. Without objection, I may at this point indicate we have had statements submitted by other prospective witnesses, and without objection, I would ask that the staff make those statements part of the record.

pages tightly bound

We are anticipating some further information being submitted and the record will be held open a sufficient amount of time for the staff to receive and insert it in the record.

Mr. BROMBERG. I would like to note a couple things factually first. One is that the market basket for hospital costs which is about close to 6 percent, 5.6 right now, happens to be just about the same percentage as the capital add-on proposed by the administration.

So that, in effect, the 6 percent market basket, which we are not going to get because of the freeze or something close to that freeze, is really the total amount of money in the whole capital pot. Just for the record.

Chairman STARK. Is that coincidental, do you suppose?

Mr. BROMBERG. I don't think it is. Also not coincidental are the numbers Dr. Helms read to you translates to me as something akin to a freeze in capital payment for those years, and I point out for those interested in whether we need to spend capital or not that over 40 percent of all the hospital beds in America are now over 30 years of age, which means there is need for renovation. Many are Hill-Burton hospitals built in the fifties and they need modernization.

There was a lot of unity today. I wish Jack were still here. He commented that there isn't a lot of unity for the issue. Once we had the experience of not getting the prospective payments rates increased, a lot of us supportive of prospective payment across the board, were thinking who we can trust. In particular, there seemed to be a lot of unity on the issue that lengthening the transition itself is not the answer, that while 7 and 10 are better, the problem is what to do.

In terms of the testimony, we make several points. One is that we question the legal authority of the administration to do this by regulation and we hope you will do it by law, but pending that, we urge you to consider an amendment as early in the year as possible to clarify that the Secretary cannot do this by regulation without congressional approval.

In terms of the proposal, we want to say constructively, we have been doing a lot of work on this. We believe that there is a compromise that can be looked at which would be budget neutral and would satisfy a lot of the witnesses you have heard today—that basically is one, saying that we will take a capital add-on for capital expended after a specified date, but not for one before.

The point has been made about what is inherently unfair about this. A manager can do a lot to cut costs on the operating side, but once he is committed to a capital obligation, he is helpless, and therefore, you are not rewarding good behavior and efficiency. You are talking about windfalls and losses, a concept I don't agree with on the operating side at all.

A transition period for all capital does not remedy the problem because things may run for 20 years and therefore the compromise is one limiting legislation to new capital expenditures. Old capital could be converted to a capital rate.

Take two hospitals, one with a 28 percent capital ratio and another one that is down at 2 or 3. I think both would benefit under this kind of a formula because what would happen is that the first

hospital would get a prospective rate equal to a 28 percent add-on for old capital, but as they spent new capital, that would come down and perhaps at the end of the 10th year be folded in.

Perhaps an inner-city or rural hospital that needs to renovate could get to the 6 or 7 percent add-on faster than 5, 7 or 10 years by spending more new capital. Each hospital would figure out how much of its capital is old and how much is new. That would keep it budget neutral and get one rate for the old and a straight add-on for new capital after that date.

I would give you the precedent for it, which I think is important, and that is that when you do tax legislation, you always do it this way.

You just, for example, repealed the investment tax credit. I don't think anyone would dare propose that you repeal it for obligations made prior to last year.

Chairman STARK. The administration proposed that, I remind you.

Mr. BROMBERG. I would hope this committee sticks to its history. I will stop at that point and thank you once again.

[The prepared statement follows:]

STATEMENT OF

MICHAEL D. BROMBERG

EXECUTIVE DIRECTOR

FEDERATION OF AMERICAN HEALTH SYSTEMS

Summary

1. We question the statutory authority of the Administration to include hospital capital payments in the prospective payment system by regulation, without Congressional action. We urge Congress to immediately pass legislation to make clear that no capital prospective payment plan can be implemented without Congressional approval.

2. It is critical that any action on capital should be at the very least budget neutral. The President's budget calls for savings of $456 million from its capital plan in the first year alone, FY 1987. We ask the Subcommittee to adopt the more realistic definition of budget neutrality - total expenditures which are no more or no less than would have been spent under existing law.

3. When Congress enacted the prospective payment system in 1983, the rationale for the use of prospective rates for all hospitals based on average costs, was that facility managers could lower their operating costs through efficiencies in such areas as labor, supplies, and length of stay. That rationale cannot be applied to capital, particularly capital expenditures already obligated. Thus we urge the Subcommittee to treat old, that is existing, capital in a manner similar to current law.

4. If Congress establishes prospective payment rates for new capital it is essential to assure equitable annual increases. If old capital is included in the prospective rates, the transition period must be sufficient to mitigate the harm done to

higher than average capital cost hospitals. Any period less than ten years is inadequate. Any new payment system for capital should not begin until October 1, 1987 (FY 1988) to allow hospitals time to prepare for the change to a prospective system for capital and its effects.

5. There is no rush to implement a new Medicare prospective system for capital. Medicare payments per case by diagnosis are fixed so hospitals will avoid higher capital spending that generates higher operating costs.

6. Tax subsidies have lowered the costs of not-for-profit debt. However, many hospitals are reaching the limit of their debt carrying capacity and will have to increase their equity base. Greater competition and payer cost consciousness are putting pressure on profits (surplus), the internal source of equity. The traditional sources of external equity - philanthropy and government grants - have declined dramatically.

The Federation of American Health Systems is the national association of investor-owned hospitals and health systems representing over 1,300 hospitals with over 154,000 beds. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities, the investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on capital financing under the Medicare program.

Regulatory vs. Legislative Action

The President's fiscal year 1987 budget proposes including hospital capital payments in the prospective payments sys-

tem, through regulatory action. We question the statutory authority of the Department of Health and Human Services to take such unilateral action.

The 1983 Medicare Prospective Payment System (PPS) law assumes Congress will pass a capital plan as evidenced by the statutory directive to mandate section 1122 capital expenditure reviews if Congress does not act.

In order to clarify this point and prevent costly, lengthy, and confusing litigation, we urge Congress to immediately pass legislation to make clear that no capital prospective payment plan can be implemented without Congressional approval.

Budget Neutrality

The President's budget calls for savings of $456 million from its capital plan in the first year alone, FY 1987. This is a cut or at best a freeze in capital which can only be characterized as a freeze in medical technology or a prohibition against progress in inpatient treatment of illness. That kind of rationing should be debated carefully. There are already signs that private research and development funding is being slowed by manufacturers of medical equipment. They fear that hospitals will not be able to pay for either incurred capital costs or the increased operating costs of new services with Medicare DRG rates not keeping pace with inflation. We urge the Subcommittee to adopt the more realistic definition of budget neutrality - total expenditures which are no more or no less than would have been spent under existing law.

If the Medicare program is unwilling to contribute its fair share toward needed capital improvements in our health system, then Congress should recognize that such improvements constitute "non-covered services" and can be charged to patients.

It is critical that any action on capital should be at the very least budget neutral.

Old Capital

When Congress enacted the Prospective Payment System in 1983, the rationale for the use of prospective rates for all hospitals based on average costs, was that facility managers could lower their operating costs by improving productivity through efficiencies in such areas as labor, supplies, and length of stay. That rationale cannot be applied to capital, particularly capital expenditures already obligated. The payment of some average capital amount to a facility with existing above average debt leaves that hospital manager helpless to do anything to lower those costs.

Similarly under DRG operating rates, lower cost hospitals are rewarded for their presumed efficient management but if hospitals with low capital costs are paid a higher rate based on averages, that can only be regarded as a windfall, not a reward for efficient management.

For these reasons we urge the Subcommittee to treat old, that is existing, capital in a manner similar to current law. This Committee has historically acted in just that manner when passing tax legislation dealing with capital. Recent action by the Committee to repeal the investment tax credit, for example, is prospective in its application and recognizes that businesses can do nothing to reverse previous decisions obligating capital expenditures.

A transition period for old capital does not remedy this problem, because the fixed obligations run for many years. It merely postpones the inequitable treatment. We therefore urge you to limit any legislation incorporating capital into DRG rates to new capital expenditures.

New Capital

If Congress establishes prospective payment rates for new capital it is essential to assure equitable annual increases which are based on an economic index reflecting changes in capital costs, such as interest rates, construction costs, and technology changes.

This concept of a fair annual rate of increase was recognized with respect to operating costs when the Medicare prospective payment system first was enacted in 1983 but it has been ignored by the Administration and Congress since that time. It is very difficult for hospital managers to believe it will be any different for capital. At the very least any legislation approved by the Subcommittee should restrict the regulatory power of the Department to reduce or freeze capital payment rates and annual increases without Congressional approval.

If old capital is excluded from prospective rates and paid for as under present law, then the issue of the transition period becomes relatively less important; we would, however, urge the new system not begin until October 1, 1987 (FY 1988) to allow adequate time for hospitals to prepare for the switch over to prospective capital payments and the effects.

If old capital is included in the prospective rates the transition period must be long enough to mitigate the harm done to higher than average capital cost hospitals. Any period less than ten years would be inadequate. We would also recommend a weighted transition so that actual or hospital specific costs would be more accurately recognized in the earlier half of the transition period.

There is No Need for Precipitate Action

Part of the sense of urgency to replace cost based yment for capital has come from concern that the continuation the status quo would set off a capital spending boom. This ar is greatly exaggerated and not supported by experience. e rate of increase in hospital capital spending has declined om over 20% in 1981 to 8.8% in 1984. The 1985 increase is lieved to be lower still. We believe the Medicare prospective yment system will restrain capital expenditures beyond the pectations of many policy analysts. The reason is that while pital costs (depreciation, interest and return on equity) e now excluded from Medicare's DRG rates, the operating costs sociated with new capital expenditures are not.

If, for example, a hospital purchases a Magnetic Resonance Imager (MRI) machine for $2 million, it will receive Medicare cost reimbursement for the depreciation and interest, but cost reimbursement for the technician hired to operate the quipment, or the maintenance costs associated with the new ervice. Unlike the old cost based reimbursement system, a ospital adding a new service such as a burn unit or a coronary are unit will recover capital costs but receive no direct reimursement for the personnel hired to staff these units. Since very dollar of capital spending produces about 22 cents of nnual operating costs on average, the absence of assured reimursement for capital related operating costs will act as a ery real impediment to capital expenditures, especially new, igh cost technology. To illustrate, the ratio of operating osts to capital costs for coronary care units ranges from 1.2 o 3.8; ultrasound from .7 to 1.3 (1). Simply put, the new

) Arthur D. Little, "Development of a Evaluation Methodology or Use in Assessing Data Available to the Certificate of Need CON) and Health Planning Programs," Department of Health and uman Services, Office of the Assistant Secretary for Health, ontract Number 233-79-4003, April 1982.

Medicare DRG prospective payment system, which limits hospital reimbursement to a set payment per case by diagnosis regardless of what type or amount of services the hospital provides a patient, has for the first time placed hospitals directly at risk for increased costs due to both operating and capital-related decisions.

Some of these capital-generated operating costs would normally be recovered under an intensity index, but the Medicare prospective payment rates were increased only 5.2% in fiscal 1985 and zero percent so far in fiscal year 1986. Since new capital spending generates higher operating costs, but Medicare's payment for operating costs is fixed by diagnosis, there is little incentive to invest in cost increasing technology. These new operating cost restraints which reward cost efficient behavior by hospitals through incentive payments, are sufficiently strong so that hospitals will not find it in their interest to expand high cost acute care capacity. There is a strong incentive to invest in cost reducing technology.

Furthermore, since capital costs are only 7 percent of Medicare reimbursement, even a large increase in capital investment by hospitals far beyond any reasonable expectation would have only a minor impact on overall reimbursement. More importantly, since the 93% of Medicare reimbursement going for operating costs is now controlled through the DRG prospective payment system, the remaining 7% attributable to capital costs has been and will continue to be restrained. Since the status quo would not generate perverse behavior, and since capital costs vary so widely among hospitals, we do not think that there should be a rush to implement a new Medicare capital payment system on October 1, 1986.

Future Hospital Capital Needs

Current hospital stock is aging rapidly and will at

some point have to be renovated or replaced, to meet life and safety code requirements, accreditation requirements of the Joint Commission on Accreditation of Hospitals, and to maintain the current quality of healthcare services provided to Medicare patients. Approximately 40 percent of all U.S. hospital beds were built in the 1950's and early 1960's during the prime of the Hill-Burton program. Those beds are now at or nearing an age of thirty years and need major renovation. Such capital replacement will not be possible if hospitals cannot make a profit or generate a surplus. Given the administration's capital proposal, contained in the Fiscal Year 1987 budget, and the restrictions on increases in hospital payment rates under prospective payment, hospitals will not be able to generate capital internally. Even if there were no expansion of the hospital system, these policies would not provide hospitals sufficient income to even maintain their plants.

The Key to Adequate Total Capital is an Adequate Equity Base.

What will determine whether the capital supplied is adequate and whether it will be put to the uses society values the most? The key to raising adequate capital is a sound base of permanent capital. Before a hospital can borrow money, it has to show the lender that it has a base of permanent capital large enough to assure that even if the hospital experiences unexpectedly poor revenues, there is still enough money to pay interest and meet principal repayment obligations, finance innovation and provide working capital.

The technical term for permanent capital is equity. Investor-owned hospitals and not-for-profit hospitals have the same internal source of equity - profits or surplus.

For-Profit and Not-For-Profit Hospitals Have Different Sources of External Equity Capital

For-profit and not-for-profit hospitals have very different sources of equity. Investor-owned hospitals can raise outside capital in the equity markets. We estimate that for-profit hospitals have raised over $2 billion in equity capital from outside investors.

The external sources of equity for not-for-profit hospitals have been running dry just at a time when the need is increasing. Historically, not-for-profits have relied on tax deductible gifts, or philanthropy, and government grants - none of which investor-owned hospitals are allowed to receive. Before World War II, philanthropy provided about two-thirds of hospital capital. The Hill-Burton program, enacted in 1946, provided about $4 billion in government grants to nearly 4,000 hospitals before it was converted to a loan guarantee program in 1970.

During the 70's, the flow of permanent capital to not-for-profit hospitals slowed from a flood to a trickle. For example, from 1973 through 1981, annual government grants for hospital construction declined from $635 billion in 1973 to $521 million in 1981 ($274 million in 1973 dollars). Annual philanthropy for hospital construction showed an even steeper decline from $302 million to $168 million ($88 million in 1973 dollars).(2) To offset these declines, many not-for-profit hospitals radically increased their long term debt, primarily tax exempt bonds, as a percent of total capitalization.

Investor-owned hospitals by virtue of their promise to pay investors a competitive return have access to an asset that will soon be a short supply in the hospital field for the

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2) Source: Federation of American Hospitals, based on data from "Trends in Capital in the Hospital Industry," prepared by Maureen Metz of the American Hospital Association, revised March 1, 1983, p.7.

forseeable future - equity capital. If this ability to earn a fair return for people who have supplied their capital is impaired, new capital will not be available. Since investor-owned hospitals have been a major force in bringing new technology and better medical care to areas of the country that have not had it before, a narrowing of geographic disparities in the quality and sophistication of care depends importantly on continued access to equity capital.

Conclusion

In summary, if the hospital sector is to have adequate capital and if that capital is to be used efficiently, a Medicare prospective payment system must be fair. The Federation of American Health Systems pledges its cooperation to the Department and Congress in efforts to develop a capital prospective rate because we continue to believe that Medicare payments should be totally prospective. A fair Medicare price will restrain all hospital costs, including capital, but an arbitrarily low price will reduce capital spending below what consumers and communities have a right to expect in modern hospital technology and quality of care.

Chairman STARK. Mr. Kuchler.

STATEMENT OF JOSEPH KUCHLER, DIRECTOR, FEDERAL ISSUES, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Mr. KUCHLER. Thank you, Mr. Chairman.

I think you will find some of my remarks echo some of the remarks that Mr. Bromberg made, and those Mr. Owen made earlier, and will underscore the unity that is building in the field on this issue.

Mr. Chairman, I am Joseph Kuchler, director of Federal issues for the Healthcare Financial Management Association, and I am pleased to present our association's views on the issue of paying for capital costs under Medicare's prospective price setting system.

HFMA is a professional membership association of more than 25,000 individuals who share an interest in the financial management of hospitals and other health care facilities. Our membership includes financial managers from every type and size of hospital—in other words, the individuals who have primary responsibility for the access to and use of capital by hospitals and for the fiscal health of the institutions in which they work.

In April 1984, HFMA's capital study steering committee issued its recommendation for a capital payment methodology. A copy of those recommendations is attached to our formal statement.

In the time remaining, I would like to highlight five main elements of HFMA's recommendations on capital.

One, capital costs for each hospital are relatively fixed, with commitments for capital spending made for long periods of time. Accordingly, hospitals' capital commitments cannot change with increases in patient volume or in response to payment changes phased in over a short period.

Further, each hospital has its own capital cycle. Some have recently replaced their physical plant and have incurred capital obligations far in excess of a national average. Other hospitals have low capital costs now but will need to replace their plant in a few years.

Because of these two realities, the fixed nature of capital and hospitals' varying capital cycles, HFMA believes that fair payment for capital must consider the circumstances of individual hospitals and include a transition period of at least 10 years for plant-related capital to give individual hospitals a chance to adjust to new rules.

Two, although the current focus on budget savings may encourage consideration of proposals that cut capital spending, HFMA would stress that fair payment for capital must be divorced from budget-cutting objectives. Capital is a very small portion of total Medicare spending, and HFMA urges the subcommittee to support capital payments that are neither more nor less than what would be spent under current law.

Three, there is a wide variation in the way capital is distributed among hospitals, and payment methods that rely on the use of national averages may cause large redistributions of capital among different types of hospitals. HFMA urges the subcommittee to use the most current available data to determine the effects of various proposals on different types of hospitals.

Four, any new capital payment methodology should eliminate any bias for hospitals to incur capital costs in preference to operating costs. HFMA believes such a bias would be substantially reduced once the equipment portion of capital is incorporated into the payment rate.

Five, finally HFMA believes that hospitals' capital expenditures are already constrained under the present system. PPS discourages higher operating costs, and capital spending generally leads to higher operating costs. Because of PPS, hospitals are now likely to use current assets longer and to postpone capital projects.

Many capital decisions now are for refinancing current debt rather than undertaking new capital projects. Because the current system does constrain capital spending, HFMA sees no need to link capital payments with health planning, whether under section 1122 or certificate-of-need requirements.

Mr. Chairman, that concludes my summary of HFMA's views. I will be happy to answer any questions.

Thank you very much, Mr. Kuchler.

[The prepared statement follows:]

HFMA

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

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STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA)
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S HOUSE OF REPRESENTATIVES
ON THE
METHODOLOGIES FOR PAYMENT OF CAPITAL-RELATED COSTS
UNDER MEDICARE

February 24, 1986

SUMMARY

- Capital costs for each hospital are relatively fixed and each provider has its own capital cycle. Therefore, fair payment for capital must consider the circumstances of individual hospitals and include a long transition period of at least 10 years for plant capital to give individual providers an opportunity to adjust to new rules.

- The current focus on budget savings may encourage proposals to cut capital spending. We urge the subcommittee to support at least budget neutral payment amounts to recognize the already existing commitments of providers and the essential nature of capital.

- Averaging methodologies may cause large and inappropriate redistribution of capital between providers. HFMA recommends that decisions be made based on accurate and timely data.

- Any new capital payment methodology should eliminate any bias for hospitals to incur capital costs in preference to operating costs. HFMA believes such bias would be substantially reduced once the equipment portion of capital is incorporated into the payment rate.

- Capital expenditures are already constrained under the present system because of the relationship between capital and operating costs. HFMA sees no need to require Section 1122 approval of capital expenditures to obtain capital payments from Medicare. Nor do we see any further need for certificate-of-need requirements under health planning.

ABOUT HFMA

I am Joseph A. Kuchler, Director of Federal Issues for the Healthcare Financial Management Association (HFMA). HFMA is pleased to present testimony regarding methodologies for payment of capital-related costs under Medicare's prospective price setting (PPS) system.

HFMA is a professional membership association composed of over 25,000 individuals in 74 chapters who share an interest in financial management of hospitals and other healthcare institutions. HFMA's members include representatives from all major types of hospitals; urban and rural, large and small, investor-owned and tax-exempt, teaching and nonteaching, freestanding and multiple facility. In addition, our membership includes public accountants, financial consultants, and investment bankers, as well as representatives of Blue Cross, commercial insurors, and others who pay for healthcare services. These are the individuals with primary responsibility for access to and use of capital and the fiscal health of hospitals and other institutional healthcare providers across the country.

HFMA has long been involved in the development of an appropriate Medicare capital payment methodology. In April 1984, HFMA's Capital Study Steering Committee issued its recommendation for a capital payment methodology (attached). It is important to recognize that the

committee's recommendations have sound philosophical and technical underpinnings. While other specific methodologies may differ from this proposal, it is essential that these philosophical and technical characteristics be recognized and satisfied in whatever capital payment methodology is selected.

FAIR PAYMENT AMOUNTS

The most widely discussed capital methodologies provide for an integrated PPS payment rate that compensates for both capital and operating costs. Initially, a separate rate for capital would be developed, but that distinction would be eliminated over time. This rate would be based on averages of costs of all providers. This is similar to the approach being used for PPS operating payments. However, this use of national averages will not yield a fair payment amount because of the relatively fixed nature of capital and the differing composition and capital cycle of each provider.

Fixed Nature of Capital

Major portions of a hospital's capital costs are represented by commitments made for long periods of time. The buildings and equipment have long periods of usefulness and long periods of planning precede their aquisition. Furthermore, hospitals rely heavily on debt to finance their capital needs and require stable cash

flows to satisfy debt obligations. These debt obligations generally are for periods of 25 to 30 years. These characteristics are much different from operating cost, which is variable to a high degree. The reality that capital commitments cannot change with increases in patient volume or in response to short range payment method changes must be recognized in any capital proposal.

Varying Capital Cycles

The second difference is that hospitals have varying capital cycles. Some providers may have recently replaced their plant and thus incurred fixed obligations far in excess of industry averages. Other providers may need new plant in a few years and, therefore, have current cost below the average but will soon have needs in excess of an average. The analysis done to date documents the wide variation in ratios of plant to operating cost which exist for very valid reasons.

Accordingly, HFMA believes that any payment method for capital should recognize the existence of both the fixed nature of capital and providers' varying capital cycles. Using industry average cost as a basis of payment rates will result in wide variations between cost and payment among hospitals.

While we believe hospitals can adjust their operations and decisions to allow immediate incorporation of equipment into PPS rates, a much longer transition than was used in PPS is vital for plant capital. The average length of capital commitments is 25 to 30 years. Cash flow required for debt service usually exceeds capital costs until at least the eighth year. Therefore, HFMA believes a heavy emphasis must be placed on current hospital-specific cost experience for plant capital for the first eight years of a transition period of at least 10 years. Average rates used in any transition blend must also be based on the most current industry data possible.

ADEQUACY OF PAYMENT AMOUNTS

Fair payment rates for capital must be divorced from budget-cutting objectives. HFMA recognizes that Medicare funding is limited, but would point out that capital is a very small portion of total Medicare expenditures. In 1984, estimated Medicare hospital capital-related payments totalled about $2.9 billion, compared to Medicare outlays for inpatient costs of about $36 billion, according to an analysis by the Congressional Research Service that was prepared for the Senate Finance Committee. Accordingly, we urge that aggregate expenditures for plant capital be neither more nor less than what would be spent if current law were continued. This "budget neutral" aggregate amount of spending, coupled with a heavy emphasis on current hospital-

specific costs during a long transition period, would help prevent both extreme shortfalls or windfalls. Some portion of the aggregate payment amount might be segregated to safeguard hospitals with unusual past obligations or that receive inadequate payments to finance essential new capital projects.

DATA-BASED DECISIONS

Any method of incorporating capital into PPS must be based on data that takes into account the effect of the payment method on various types of hospitals. There are wide variations in the way capital is distributed among hospitals, and care must be exercised to prevent large, unnecessary, and unjustified redistributions of capital among providers. Limited data collected by HFMA indicates that the range of percentages of capital to operating costs is 1.9 to 19.4. Other data now being collected and analyzed by various parties demonstrates similar findings, and HFMA recommends that Congress study this data to determine whether such factors as bed size, teaching status, age, or location must be considered, in the development of a capital payment plan. Analysis of the effects of specific methodologies on individual hospitals and communities is also necessary. Until the answers to these questions are known, clear decisions cannot be made. We encourage you to make your recommendations based on thorough, accurate

analysis of the effects of the various proposals you will consider.

INCENTIVES OF A NEW CAPITAL PAYMENT SYSTEM

HFMA believes that any new capital payment methodology should provide incentives for cost effective hospital management without a bias favoring either capital or labor expenditures. Under the current passthrough, for example, a hospital might choose to purchase an autoanalyzer to perform certain routine clinical laboratory tests rather than hire additional personnel. The autoanalyzer, a piece of moveable equipment, would be paid for through the passthrough, whereas adding more personnel would only increase operating costs -- which PPS discourages. There is a much more direct relationship between equipment-related capital costs and operating costs than between plant-related capital costs and operating costs. Therefore, we see no reason not to incorporate payments for equipment into an integrated rate. However, we have concerns about incorporating plant capital because of the variations in plant costs among hospitals and the fixed nature of capital. We believe any capital vs. operating cost bias would be substantially removed if equipment capital were incorporated into the payment rate under PPS.

LINKAGE WITH SECTION 1122

Design of a system for Medicare payment for capital-related costs for most hospital inpatient services must recognize that capital-related costs are a relatively minor part of total Medicare annual expenditures, but at the same time are as vital to hospitals' continued existence as capital is to any enterprise. Although capital expenditures by hospitals are large, hospitals spend far more for labor and other operating costs. Adequacy of payments for operating costs is crucial. Providers have responded to the incentives of PPS to enhance overall productivity, efficiency, and effectiveness and to limit all hospital expenditures, including expenditures for capital. Because capital investment generally increases operating costs, PPS places hospitals at risk for both operating and capital decisions. There is no incentive to make capital expenditures if there is limited funding for operations. Because of PPS, hospitals are now likely to use assets longer, to delay or cancel new capital projects, to curtail the size of essential capital projects, and to seek the lowest cost of financing capital assets if essential quality of care considerations permit.

Many argue that the current passthrough of capital costs creates an incentive for hospitals to increase capital spending. However, current experience does not support this concern. Current capital spending is primarily for

refinancing. In the present period of low interest rates, many hospitals are refinancing their debt to reduce their capital costs. Current capital spending is not adding inappropriately to capacity or otherwise adding to healthcare costs.

For the reasons just mentioned, HFMA believes that capital costs under the present system are constrained. Accordingly, we see no need to link capital cost payments with health planning. Therefore, the requirement for Section 1122 approval of capital expenditures is unnecessary. We also see no need for continuation of certificate-of-need requirements under the federal health planning program.

CONCLUSION

To summarize HFMA's views, I would again stress the following points:

Hospitals have responded well to the incentives provided by PPS, and a change in capital payments is not essential to furthering these incentives. However, the wrong capital payment arrangement could undermine the achievements under PPS and endanger the fiscal health of hospitals. To achieve positive results, hospitals must be assured that capital payments are fair and not designed simply for budget-cutting objectives. Budget neutral aggregate capital expenditures

will evidence the fairness of a new system. Rates based on broad averages redistribute payments inappropriately among providers and are undesirable. There must be heavy emphasis on hospital-specific cost experience in new payment rates. A long transition of at least 10 years is necessary to recognize the fixed nature of capital. The new methodology must substantially eliminate any bias for management's use of capital vs. operating cost. HFMA believes this would be substantially achieved once equipment is incorporated into the payment rate. Capital cost increases usually result in increased operating costs. Therefore, existing PPS constraints on operating costs sufficiently control capital expenditures and there is no need for linking capital cost payments with health planning. Further evidence of the effect of current constraints on capital is the fact that current capital spending is largely used to refinance long-term debt, thus reducing both interest costs and payments by the Medicare program. This is a clear indication that the passthrough of capital cost does not create perverse incentives.

This completes my testimony. I will be happy to answer any questions the subcommittee may have.

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PROPOSED METHOD OF MEDICARE PAYMENT FOR HOSPITAL CAPITAL-RELATED COSTS

Recommended by:
Capital Steering Committee

April 19, 1984

This recommended position statement has been prepared by HFMA's Capital Steering Committee. This recommended position does not represent a position of HFMA.

OBJECTIVE

The objective of this document is to propose a method for Medicare's payment of hospitals' capital-related costs associated with most inpatient services in connection with the Medicare prospective price setting (PPS) system as presently designed. This method is not related to such future alternatives as capitation.

Public Law 98-21[1] initiated new rules governing Medicare payment to hospitals for most inpatient services. This new plan is effective with each hospital's fiscal year beginning on or after October 1, 1983. Prospectively determined prices compensate hospitals for the operating costs of covered inpatient cases. Cases are classified by diagnosis related groups (DRGs). In contrast to the former cost-based, retrospective reimbursement system that emphasized penalties, the new system provides incentives to hospitals to manage their operations in a cost-effective manner.

Congress excluded capital-related costs[2] (depreciation, interest, rent and return on equity) from these prospective prices. Instead, it chose to continue the former practice of paying each hospital its own capital costs while alternative methods are evaluated. To aid Congress in dealing with capital-related issues under the Medicare program, the Secretary of Health and Human Services is required to complete a study, prepare a report to Congress and propose legislation concerning Medicare payment for capital-related costs.[3] Congress has not yet decided on the final method of paying for capital-related costs. However, the method selected is likely to emphasize predictability and controllability of federal spending.

HFMA desires to foster concensus within the industry and with the Congress on this important issue and believes the examination of alternatives is essential to that objective. Various alternative

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[1] U.S. Congress, Social Security Amendments of 1983 (Public Law 98-21), Title VI, "Prospective Payments for Medicare Inpatient Hospital Services" enacted on March 24, 1983. See U.S. House of Representatives Report No. 98-47.

[2] Capital-related costs are defined in Section 405.414 of the Medicare regulations. See Federal Register (Vol. 48, No. 171, September 1, 1983, pages 39809 to 39811).

[3] Public Law 98-21, Section 603(a)(1). See U.S. House of Representatives Report No. 98-47, pages 107-108 and 203.

methods of Medicare payment for capital-related costs have been proposed -- each with strengths and weaknesses. This proposal has been refined after giving consideration to review comments by HFMA's members and others on two occasions and reflects the recommendations received and gives consideration to alternative methods proposed by other organizations. HFMA believes that, at this point in the development and evaluation of alternatives, this proposal would best serve the needs for the industry, the interests of various involved parties and the objectives of Congress.

April 19, 1984

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SUMMARY

HFMA's proposal, as described on page 8, recommends that:

1. equipment-related costs should be added to and incorporated within the prospective case price; and

2. plant-related costs should be paid for on a hospital-specific basis in addition to and distinct from the case price, and Medicare should honor its share of plant commitments throughout the life of each project.

April 19, 1984

FOREWORD

HFMA's proposal assumes that Medicare funding is limited and, therefore, seeks no additional provision for capital from that which would occur under current rules.

Current deficiencies in Medicare funding have had the adverse effect of shifting financial obligations to other payors, reducing hospital equity and undermining hospitals' fiscal viability.[4] If payments to hospitals for capital and other financial needs from all sources, including Medicare, are deficient, then hospitals will be unable to fulfill their essential healthcare mission to all patients, including Medicare beneficiaries.

Design of a system for Medicare payment for capital-related costs for most hospital inpatient services must recognize that capital-related costs are a relatively minor part of aggregate Medicare annual spending,[5] but are as vital to hospitals' continued

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[4] According to HFMA's Financial Analysis Service, hospitals' viability index ratio has shown a marked deterioration since 1978, and the replacement viability ratio indicates that hospitals have not been accumulating essential replacement funds. Since capital formation depends almost entirely on positive cash flows, the low level and recent decline in hospitals' ratio of cash flow (net income plus depreciation) to total debt is also significant. Over 50 percent of hospitals have net operating income less than replacement cost depreciation. (Source: Healthcare Financial Management Association Financial Analysis Service, Hospital Industry Analysis Report, 1982.) Also see Silvers, J.B., Ph.D. and Unger, Walter J. (Eds.), Capital Management in Healthcare Organizations: Investment and Financing Strategies, (Healthcare Financial Management Association, Oak Brook, Illinois, 1983).

[5] Inpatient hospital capital payments under the Medicare program are expected to be only 4.4 percent of total outlays in 1984 ($2.9 billion out of $66.2 billion). The ratio of hospital capital costs (including return on equity of $200 million) to operating costs is less than 7.4 percent ($2.9 billion divided by $39.2 billion). Based on fiscal year 1981 Medicare inpatient hospital cost data, Medicare inpatient

existence as to any enterprise. While capital expenditures by hospitals are large, hospitals are labor intensive.[6] Adequacy of payment for operating costs is crucial. The new Medicare PPS system creates strong incentives to enhance overall productivity, efficiency and effectiveness and limit all hospital expenditures, including capital. The new system, as already implemented, places hospitals at risk for both operating and capital decisions. There is little incentive to make capital expenditures if there is inadequate funding for operations. Hospitals are likely now to use assets longer, to delay or cancel new capital projects, to curtail the size of essential capital projects, and to seek the lowest cost of financing capital assets if essential quality of care considerations permit.[7]

HFMA believes that the amount of resources devoted to healthcare services will be most reflective of the public's preferences and most appropriately allocated if hospital prices are established

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capital expenditures for FY 1984 are projected to be $0.4 billion for depreciation of moveable assets (14%), $1.6 billion for depreciation of fixed assets (55%), $0.7 billion for interest costs (24%) and $0.2 billion for return on equity to investor-owned hospitals (7%). (Source: Rubin, Robert J., M.L., Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Address before Council of Hospital Finance Authorities, September 15, 1983 and Rubin, Robert J., M.D., and Helms, Robert B. Ph.D., "Medicare Payment of Hospital Capital-related Costs," Healthcare Financial Management (Vol. 38, No. 4, April 1984) page 21.

[6] Mean capital costs for all hospitals (excluding return on equity) equalled 6.6 percent of total costs in 1981. For one-quarter of all hospitals, capital costs are less than 4 percent of total costs. Fifty-seven percent of all hospitals have capital costs equal to 4-10 percent of total costs, and 18 percent have capital costs in excess of 10 percent of total costs. (Source: Anderson, Gerard, Ph.D. and Ginsburg, Paul B., Ph.D., "Prospective Capital Payments to Hospitals," Health Affairs (Vol. II, No. 3, Fall 1983) page 58.

[7] See, e.g., Krystynak, L.F., Ph.D., "Prospective Payment for Capital: The Financial Nature of Capital Allowances," Healthcare Financial Management (Vol. 37, No. 10, October 1983), page 60. Also see, e.g., Kalison, Michael J., and Averill, Richard, "The Response to PPS: Inside, Outside, Overtime," in Healthcare Financial Management (Vol. 38, No. 1, January 1984), page 78.

through market forces. Medicare currently has the authority to unilaterally establish prices that are not responsive to either market forces or the preferences of Medicare beneficiaries. Payments by patients are indispensable to the market determination of prices.[8] HFMA urges provision for patient payment so patients can express their preferences and so prices will reflect market influences.

Prices established through market forces can reflect the differing financial responsibilities of various payors. All hospitals must have the opportunity to recover from all patients, including Medicare beneficiaries, such cost factors as, but not limited to, depreciation, interest, return on equity and the cost of uncompensated care (i.e., the cost of charity care and other uncollectible accounts).

In the absence of a mechanism for establishing market prices, such as through beneficiary payments, special care is required to assure an adequate flow of capital to hospitals. However, the payment for capital in connection with the Medicare PPS system should be done in a way that does not add to the present federal budgetary concerns about Medicare. Methods other than those described herein might be preferable if funding were available, but HFMA's view of congressional attitudes and economic realities dictates the described choices. HFMA's proposal does not correct the overall funding shortfall, but emphasizes predictability of payments and fulfillment of long-term commitments for hospitals' capital needs. Moreover, it recognizes current and anticipated federal budgetary limitations. In the absence of these considerations, HFMA would support other alternatives that assure consistent payment of hospital's full financial requirements.

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8 HFMA's "General Guidance Concerning Prospectively Determined Prices" (adopted May 28, 1982) details the advantages of patient financial participation. Copies of this document are available on request.

PRINCIPLES AND CRITERIA

HFMA's proposal is based on the following principles and criteria:

1. recognition of present and future federal budgetary constraints,

2. predictability of Medicare income to hospitals and outlays by the Health Care Financing Administration,

3. equity among all hospitals covered by the prospective payment system without discrimination based on capital structure, payor mix or teaching commitments,

4. Medicare assurance of future capital payments at the time decisions about capital projects are made,

5. recognition of hospitals' obligations to bond holders, shareholders, mortgage holders and others,

6. incentives for cost effective hospital management with no bias favoring capital or labor expenditures.

7. decentralized decision-making,

8. understandability, and

9. practical administration.

HFMA believes this proposal is responsive to these principles and criteria.

April 19, 1984

DESCRIPTION OF PROPOSAL

HFMA proposes that Medicare compensate hospitals for capital in two components: equipment and plant.

Equipment includes major moveable equipment and minor equipment. Thus, it includes those types of capital that are purchased and turned over relatively continuously. Equipment often offers an opportunity for interchanging capital and labor. This is an essential alternative for managerial judgement, and one that must be decided in accordance with individual hospital circumstances. These assets are financed in a variety of ways, including the hospital's own funds, leases, or borrowed funds. Selection of financing alternatives is also an essential managerial judgement that depends on individual hospital circumstances. To facilitate capital/labor trade-offs, economical financing and other managerial actions and to subject the hospital to the risk of these judgements, equipment should be an integral part of the Medicare case price.

Equipment should be incorporated into the federal portion of Medicare PPS case prices using industry-wide equipment cost averages. A percentage should be determined by measuring industry-wide depreciation of equipment, lease costs of equipment, and interest on equipment-related debt and dividing the total of these costs by industry-wide operating costs (net of capital and direct teaching costs). This percentage is added to Medicare case prices. The equipment element should also be added to the hospital market basket used to calculate the annual update of Medicare PPS case prices, and updating of the equipment element by an appropriate index(s) should be a regular part of the annual update of Medicare PPS case prices. The hospital-specific portion of the rate should be based on the hospital's cost history. There should be no differentiation between equipment and other elements of the prospective case price. While there may be some minor differences in revenue to individual hospitals, the aggregate Medicare expenditures would be consistent with those under current rules and no transition system is required.

Plant includes land, buildings, fixed equipment and also includes betterments and improvements. Plant cannot be readily relocated or converted to other use. Plant is purchased episodically and often involves special review. Further, plant is often financed with debt or new infusions of equity.

Since Medicare, rather than hospitals, establishes the prices Medicare will pay, those prices must give recognition to the long-term commitments inherent in plant. Medicare should pay its share of each hospital's amortized cost of plant. The amount of

Medicare payment for plant is determined for each hospital based on its own historic cost depreciation, actual interest on plant-related debt[9] and plant-related costs such as property insurance and taxes.

Return on equity for investor-owned hospitals should be paid by Medicare along with payments for plant. Return on equity is based upon the hospital's equity capital invested in all patient care assets consistent with current Medicare payment rules.

Medicare's share of plant cost and return on equity is determined annually, and should be paid prospectively. There should be an adjustment for the difference between Medicare's share of plant cost and return on equity and the payments made during the year. This approach to paying for plant cost and return on equity is a natural extension of current practice and thereby does not require a transition system.

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[9] For leased plant, the lease amount includes both depreciation and interest; therefore, the full lease amount is included in the calculation of the plant payment amount.

BACKGROUND AND SUPPLEMENTARY INFORMATION

The material in this section describes the rationale for HFMA's conclusions.

1. Alternatives considered

HFMA's Capital Steering Committee considered several options for Medicare capital payment. These alternatives are not mutually exclusive. A hospital's own costs is one possible basis of payment. Hospitals' historic costs can also be trended forward using an inflation factor to calculate individual hospital capital payments. Individual hospital capital spending allowances can also be set by a state or local rate-setting or planning agency, possibly with consideration of some overall capital spending approval limit. Industry-wide averages can be used instead of individual hospital costs. A capital payment amount can be determined in advance, but prospective payments can be subject to a retroactive adjustment. Such an adjustment can be settled or can be incorporated into a new prospective rate. The capital factor can be separately identifiable or can be incorporated into an all-inclusive rate that allows greater management flexibility.[10] A combination of several of the above methods can be based on the type of capital. Because current analyses appear to indicate that there is no single variable that accounts for major differences in the capital cost to operating cost ratio among hospitals, formula-based methodologies applicable to all capital seem inappropriate. Therefore, HFMA's proposal incorporates the most appropriate alternative for each type of capital to achieve the best overall results.

HFMA believes that a system that introduces new incentives for cost effective plant decisions in the future while at the same time incorporating allowances for some presently unrecognized financial needs would be more desirable than any method presently proposed. However, if aggregate capital payments are to be held at the level established by current rules, funds for any incentives must come from a redistribution of payments among hospitals. This redistribution would result in payment shortfalls to many hospitals that would not be fair nor just. HFMA believes the present incentives of the new PPS system, already in place, will restrain capital payments below the

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10 An annotated reference list of selected literature analyzing various alternatives reviewed by HFMA's Capital Steering Committee in reaching its conclusions is available upon request.

expectations of many policy analysts. These savings may make the introduction of new incentives for future capital and recognition of unmet needs possible in the future. Recognition of the appropriateness of return on equity regardless of ownership, should have high priority when resources permit.

2. Access to capital

The capital-cycle concept was considered. A transition system that protects hospitals at the high point of the capital cycle (those that have recently made major capital commitments) can be devised. HFMA believes hospitals at the low point in the capital cycle at the time of conversion to a new system also require special protection to avoid being permanently disadvantaged. Those needing capital in the near-term future for normal periodic projects need provisions that will help assure availability of capital. HFMA's proposal helps assure capital when needed.

3. Prospectivity

Ideally HFMA believes prospectivity should apply to all elements of Medicare prices. This recommendation favors prospective decisions and commitments about plant projects when it really counts -- before the project is undertaken, not annually after the project is built and as prices are set in a possibly changing economic atmosphere.

4. Equipment and plant considerations

This proposal's differentiation between equipment and plant is consistent generally with industry practice and with current Medicare rules. Industry and Medicare data already differentiate on this basis. Handling equipment as a part of Medicare prospective prices minimizes questions about whether these items are capitalized or expensed.

Individual items of equipment do not appear to have the same variations of cost based on location as do costs of labor, food or energy. Thus, equipment does not have a consistent percentage relationship to other operating costs. However, hospital management can adjust equipment purchasing decisions within available funding. If this proposal is implemented during the PPS transition period, the hospital-specific portion of hospital inpatient rates will further recognize each hospital's short-range equipment purchasing history.

5. Return on equity

HFMA believes that a return on equity after taxes is essential to hospitals of all ownership types. A return on equity is necessary to attract capital and to fulfill expectations of those who have provided capital. Owners of tax-exempt and investor-owned enterprises expect a return for such purposes as dividends, charity care and fulfillment of institutional mission.[11]

While HFMA believes Medicare rates should provide a return on equity to all hospitals, such a change would add significantly to aggregate Medicare spending. HFMA recognizes that federal Medicare spending objectives do not permit adding return on equity into prices paid to tax-exempt hospitals at this time. Since the current amount of aggregate Medicare spending for return on equity is less than one-half of 1 percent of total Medicare expenditures, HFMA supports retention of the existing return on equity provisions for investor-owned hospitals.

Return on equity involves the differences between tax-exempt and investor-owned hospitals, such as access to investment capital, philanthropy and the extent of use of tax-exempt financing. It is unrealistic to attempt to adequately take these differences into consideration and try to equalize them as a by-product of Medicare payment for capital under the current PPS system.

6. External approval

HFMA favors discontinuation of external approval of capital projects. External approval should not be a prerequisite to Medicare paying for its share of capital expenditures. Hospital managers and trustees have a good record of prudent capital decisions consistent with community needs in the context of the incentives of the payment arrangement in effect at the time. The new Medicare PPS system has already introduced strong restraints on capital expenditures. This proposal strengthens those incentives even further with respect to equipment.

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11 See, e.g., Long, Hugh W., Ph.D., "Preserving Capital: Asset Choice and Program Selection in a Competitive Environment," in Healthcare Financial Management (Vol. 36, Nos. 7 and 8, July and August 1982). Also see, e.g., Furst, Richard W., and Roenfeldt, Rodney L., "Estimating the Return on Equity Capital," in Hospital Financial Management (Vol. 35, No. 6, June 1981), and Cleverley, William O., "Accounting Return on Equity in the Nonprofit Hospital," in Hospital Financial Management (Vol. 35, No. 7, July 1981). All three of these articles are reprinted in Capital Management in Healthcare Organizations (op. cit.).

Plant expenditures are constrained and guided by many influences in addition to the sound judgement of managers and trustees. The new Medicare PPS system discourages increases in operating cost that usually accompany capital spending.[12] Furthermore, plant expenditures are made with consideration of total revenue including payments by all payors using a variety of payment methods, including payment of prices established in response to market forces (the most preferred constraining influence). External review will also continue to be exercised by bond underwriters, rating agencies, business coalitions, philanthropists and the public through the press.

7. Timing

It is desirable to eliminate the current uncertainties about Medicare's capital payment policies. Public Law 98-21 provides that costs related to capital projects initiated on or after March 24, 1983, ("new capital") may or may not be treated differently from projects initiated before that date.[13] Thus, no assurances are given that capital costs related to projects obligated (as defined by regulations under Section 1122) after March 23, 1983, will continue to be paid on a reasonable cost basis. HFMA believes its proposal can be implemented with relative ease, will not cause inappropriate reallocations of funding and will contribute to predictability of payment. Therefore, HFMA urges a prompt decision and prompt implementation.

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[12] A dollar in capital investment increases, on average, annual total hospital expenditures by 22 cents according to Arthur D. Little, Inc., "Development of an evaluation methodology for use in assessing data available to the certificate of need and health planning programs," Office of the Assistant Secretary for Health, Contract No. 233-79-4003, 1982.

[13] Public Law 98-21, Section 601(a)(3). See U.S. House of Representatives Report No. 98-47, pages 90 and 190.

HFMA'S CAPITAL STEERING COMMITTEE

This recommended position was prepared by HFMA's Capital Steering Committee that includes representatives from all major types of hospitals: urban and rural, large and small, taxable and tax-exempt, teaching and nonteaching, and freestanding and multiple facility. In addition, it includes an investment banker, a public accountant, a manager of a freestanding ancillary services provider and a prepaid health plan manager. The Steering Committee issued two exposure drafts (November 23, 1983 and January 18, 1984). Suggestions were received in advance of preparation of the initial exposure draft and in response to the two exposure drafts. All review comments have been carefully reviewed and considered along with views and positions of others. Members of HFMA's Capital Steering Committee are:

John Eresian, Steering Committee Chairman
Vice President Finance and Treasurer
Northwestern Memorial Hospital
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Robert Craven, FHFMA
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April 19, 1984

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April 19, 1984

DESCRIPTION OF HFMA

The Healthcare Financial Management Association (HFMA) is the personal professional membership association for all levels of financial management personnel in healthcare and related organizations. With more than 23,000 members, the association provides multifaceted programming keeping pace with a dramatically changing and shifting healthcare environment. HFMA develops and presents cutting-edge educational programming, speaks out on professional issues, provides a variety of forms of communications, authoritative direction and innovative answers to pressing questions. Each member is also served through affiliation with one of 74 active chapters organized by state or major metropolitan area. The association is dedicated to ensuring a financially sound approach to the provision of healthcare services and to enhancing the professional competence of the healthcare industry's financial managers.

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April 19, 1984

Chairman STARK. Mr. Byrnes, please proceed.

STATEMENT OF FRANCIS J. BYRNES, CHAIRMAN, MANAGING DIRECTOR OF PAINE WEBBER HEALTHCARE AND FINANCING GROUP, ON BEHALF OF THE HEALTHCARE FINANCING STUDY GROUP

Mr. BYRNES. Thank you, Mr. Chairman. It is a pleasure to be here today and have the opportunity to speak with you.

My name is Jack Byrnes. I am managing director of Paine Webber and I am responsible for Paine Webber's healthcare investment banking business. I am here today as chairman of the Healthcare Financing Study Group, which is a trade association comprising some 50 underwriting firms specializing in the financing of nonprofit hospitals. Our group includes numerous law firms and consulting firms which also specialize in this endeavor.

We have submitted written testimony to you which details our position. To capsulize our thoughts, we do not believe that hospitals should be penalized or for that matter receive a windfall profit for complying with rules established by Congress and in effect at the time capital commitments were made by them.

To retroactively allocate payments for capital on an arbitrary basis in our opinion is not necessary. All hospital fixed assets have a life cycle and must be replaced. The past timing of the replacement of those assets should not be an issue. We offer a hold-harmless solution, for lack of a better word. Why not treat old capital as you always have? Capital expense is by definition long term. Unlike operating expenses, as has been mentioned earlier, it cannot be altered or reduced quickly.

Reimburse hospitals for actual costs. Their capital investment decisions were based on a set of rules dictated by Congress. Let them live by those rules for old capital costs.

The benefit: it is budget neutral. The ones with 1 or 2 percent capital costs would get 1 or 2 percent back, and it avoids the arbitrary reallocation.

As to new capital investment decisions, by our definition, which are made after the proposed legislation is enacted, treat that differently, perhaps a flat fee for an add-on to DRG's, a national rate rather than a specific rate. No transition period or a very short one.

The key benefit: hospital managers and boards may make rational business decisions knowing that they will be paid for what they get.

I have looked at four—actually numerous examples to bring to you of the effect of a "7 percent solution" or something similar on hospitals which have undertaken capital projects in the last 3 years.

I have chosen three hospitals and one multihospital system. I have tried to compare their actual costs for already committed capital, that is presently being reimbursed under the old system versus what would happen under a 7 percent solution, giving each the averages. I have chosen four examples where the forecasts have been independently prepared. Not surprisingly, at least one of

them has been mentioned today, Good Samaritan in Cincinnati, OH.

I agree with everything Mr. Wood said and I didn't know Mr. Wood until today.

That hospital has a major, major problem and I won't go into the details. He has covered them well.

I have also looked at Orville, CA, Columbia Presbyterian Medical Center in New York, and the health system in San Antonio, TX.

In the case of Orville, capital costs average approximately 12 percent of total operating expenses. Under the 7 percent solution, the shortfall would more than offset the operating profit or excess of revenues over expenses from operations.

In the case of Columbia Presbyterian, it is very similar to what you heard from Mr. Rushkoff of Mount Sinai.

Capital costs average approximately 15 percent from 1988 into the future. The shortfall runs from $30 million on up to $40 million a year, and that hospital forecasts, or at least it has been independent forecasted, that that hospital would have approximately a break-even bottom line, so that $40 million would have to come from another source.

The health system in San Antonio is a 10-hospital system comprising 3,300 beds. It has done a number of projects over the last few years. Capital costs average from a low of 12½ percent to a high of 14½ percent.

The shortfall varies from $18 million to $30 million, far exceeding bottom line, and on a cash basis almost in as bad a shape as Good Samaritan.

In each case, there are two losers. No. 1, the patients. They are going to get either lower quality or less services.

Second, the bondholders are of concern to us. These are individuals who bought the bonds thinking that the capital expense to support the bonds would be reimbursed.

Defaults are inevitable. I contend that all hospitals that have undertaken major projects in the last 7 or 8 years would show similar results. You are seeing but the tip of the iceberg.

Thank you.

Chairman STARK. Thank you, Mr. Byrnes.

[The prepared statement follows:]

STATEMENT OF FRANCIS J. BYRNES, CHAIRMAN, HEALTHCARE FINANCING STUDY GROUP

INTRODUCTION

Good morning, Mr. Chairman. I am Jack Byrnes, Manager of the healthcare group at Paine Webber and have today in the capacity of Chairman of the Healthcare Financing Study Group. I appreciate the opportunity to testify before the Subcommittee. The HFSG is a trade association of approximately 50 investment bankers and underwriters in the healthcare field. Our members typically have 10-20 years' experience in financing healthcare facilities, and we have all been closely involved in developing financing tools to accommodate the enormous structural and payment changes occurring in this area. My comments today draw on my own experience and that of my colleagues in working with hospitals to cope with these changes.

PRESSURES ON HOSPITAL FINANCING

As you know, the debate over how to treat capital in the Medicare reimbursement system comes at a time of significant financial pressures for hospitals. While the effects of the prospective payment system on the operating side have produced some needed efficiencies, they have also squeezed margins for some institutions—particularly the large urban and small rural hospitals—into the 1% range. For such institutions, and for any which had to undertake capital projects during the high interest rate period of the late 1970s, a move away from straight reimbursement will impose additional financial pressures.

The discussion of Medicare capital reimbursement also comes at a time when Congress is contemplating tax revisions which will surely reduce the nonprofit hospital sector's ability to obtain capital at reasonable rates through the use of taxexempt bonds. As you know, this Committee's tax reform bill would reduce nonprofit hospital bond volume through a cap whose effect will be to cut available bond volume by about half of 1984 levels. H.R. 3838 would also strip hospitals' ability to reduce capital costs by lowering debt service or undertaking restructuring by means of advance refundings. Similar restrictions are under discussion in the Senate.

My point in mentioning these legislative initiatives is to stress that Medicare reimbursement for capital cannot be considered in isolation. If Congress does eventually subject hospital bonds to volume caps and/or restrict advance refunding in the course of tax reform, hospital capital costs will inevitably jump significantly. To the extent that Medicare capital reimbursement covers some of those costs, the increase will be transferred back to the Federal Treasury. To the extent that Medicare does not cover those costs and hospitals come up short, they will have no choice but to lower non-capital costs by reducing the quality of care provided. Particularly if the tax laws cut off the ability to lower debt service through advance refunding, capital costs cannot be lowered; debt service on capital improvements is a fixed expense for the life of a project. In short, we urge you to consider the adverse effects of proposed tax law changes on hospitals and the Medicare system as you develop legislation on capital reimbursement. Now let me address that subject specifically.

PHASED CAPITAL PASSTHROUGH

The proposals now circulating in Congress and the Administration employ a phased methodology, wherein capital cost reimbursement shifts from a hospital-specific to a national calculation over time. A phased approach to capital payment presents two problems. First, a phased system penalizes any institution with high current capital costs as the national portion becomes dominant. Such a system is unfair to those institutions which had no choice but to incur capital costs during periods of high interest rates. Even leaving the issue of fairness aside, arbitrarily causing economic hardship for any institution with high historic costs will, as I have suggested, inevitably have adverse effects on the quality of healthcare.

Second, a flat payment for historic capital costs, regardless of the timing, indiscriminately creates windfalls as well as hardships. There is no reason to reward institutions with below average capital costs any more than there is to penalize those with higher than average costs. This is especially true where the result would be to arbitrarily enhance the financial position and prolong the lives of some poorly managed institutions which perhaps should go out of business.

THE "HOLD HARMLESS" ALTERNATIVE

A more efficient and equitable alternative to a phased approach is to reimburse capital costs incurred prior to the introduction of the proposed legislation on a historic basis, while reimbursing all capital costs incurred after that date on a flat fee, national basis, with no transition period. The advantages of this system are as follows.

First, healthcare institutions would be "held harmless" for actions based on rules applicable at the time those actions were taken. Similarly, decisions on future expenditures could be made on rational basis, since the limits of reimbursement would be known, and management could reasonably be held accountable for the consequences. That is not true of decisions on capital undertakings made up to now. Although a possible change in Medicare reimbursement was contemplated in theory before 1986, new rules were not established—and still have not been established—leaving hospitals no choice but to follow current law.

Second, the lives of inefficient or poorly run institutions which happen to have low capital costs (in part because they have deferred needed renovations or modernizations) would not be arbitrarily prolonged.

Third, hospitals incurring new capital costs would not receive excess reimbursement on their hospital-specific portion during what would have been the early years of a phased program; likewise, hospitals with below-average costs would not receive windfalls in the later years of a transition.

The nature of a DRG-based capital reimbursement system makes it difficult to generalize about the economic consequences of any approach. However, if one assumes any fixed-fee system would be based on a true average of capital costs, our proposal should be no more expensive than a phased alternative. It simply avoids the arbitrary reallocation of capital based on historic costs. In fact, our proposal might well prove to be less expensive, since reimbursement on the hospital-specific portion would diminish as the existing capital base depreciates.

In summary, we can appreciate the budgeting pressures which affect any discussion of capital reimbursement. Unfortunately, a phased approach will allocate capital without regard to fairness, efficiency, or social good. Our proposal puts all hospitals on an equal footing, and creates immediate economic incentives for prudent management.

We would be happy to provide the Committee further data or develop this proposal in greater detail. Again, thank you for the opportunity to present the HFSG's recommendations.

Chairman STARK. Mr. Abernethy.

STATEMENT OF DAVID ABERNETHY, PRESIDENT-ELECT, AMERICAN HEALTH PLANNING ASSOCIATION, AND DEPUTY COMMISSIONER FOR PLANNING, POLICY AND RESOURCE DEVELOPMENT, NEW YORK STATE DEPARTMENT OF HEALTH

Mr. ABERNETHY. Mr. Chairman, I had heard that health planning was in trouble at the national level, so I am particularly glad you gave us the honor of the last word.

I am David S. Abernethy, president-elect of AHPA, and deputy commissioner for planning, policy, and resource development, New York State Department of Health. I was chairman of the AHPA Commission on Capital Policy, a group of distinguished experts which examined, in detail, the potential effects of various capital payment options on the health care delivery system. I have brought copies with me today and urge you to review this careful analysis of the capital issue.

To my knowledge, ours is the only effort to look at the effect of capital payment on the total health care delivery system, and the communities it affects. All other groups have focused only on the potential effects on providers.

It is our firmly held conviction that health care capital decisions must be responsive to the needs of communities. Capital policy, given its central role in shaping the health care system, must reflect that requirement.

I have attached to my testimony evidence from my own State of New York that clearly demonstrates that there is great variability in capital cost. For this reason, a fixed capital payment per admission will inadvertently reward some, while penalizing other, institutions. These rewards and penalties bear little or no relationship to a community's need.

Our data represents, I believe, the only 100-percent sample of actual data which has been presented to the subcommittee. This represents 1986 data and is up to date as of last week.

I would note in contradiction to the panel that preceded us that there is, in fact, no discernible pattern as to who does well and who does poorly under a fixed add-on.

In New York, the range in capital costs is from 1.44 percent of total costs to 29.9 percent. The high capital cost hospital is a small exurban hospital in Suffern, NY, and the low hospital is a medium-sized inner city hospital in New York City. There is apparently no pattern.

Some teaching hospitals do well, some do poorly.

Some community hospitals do well, some do poorly.

Some rural hospitals do well, some do poorly; again, no pattern.

The other thing I have noted about the testimony today is that each witness demanded a higher level of capital in the hospital system. It is our position that it is not particularly necessary to provide more capital to the hospital system. All of the proposals that have been made today have been in some sense or another implied that there is a need for a greater level of capital investment in the system. That does not seem to be the case; because what does seem to be the case is that the system as a whole may be in fact overcapitalized; that is, it has too much capacity, but the problem is that individual institutions are undercapitlized and a fixed add-on has no ability to deal with that problem.

Capital investment decisions represent the best opportunity to shape the health care delivery system of the future.

Please keep in mind that capital expenditures, once made cannot be easily adjusted. Moreover, the amount of capacity needed by the hospital system is shrinking dramatically due to the introduction of the prospective payment system, the growth of HMOs and other managed health care systems.

As a result, admissions will go down; the capacity to produce those admissions should also go down. Although a fixed add-on is simple, it cannot target reductions in capacity.

We need to manage the shrinkage across the health care delivery system as a whole, not across individual institutions, in order to ensure that limited health care resources are used as effectively as possible.

I am so personally concerned about this lack of management ability within a fixed add-on that I must urge the subcommittee that if it adopts such a system on a national level, it must provide those of us at the State level who wish to do so with the ability to manage the system within our own States.

The American Health Planning Association urges that Congress develop a comprehensive capital policy which is not limited to Medicare; has as a major component a Federal payment policy which inhibits overbuilding, improves distribution, and takes into account the needs of hospitals serving the indigent; provides support for a stable and adequately funded State and local health planning system to ensure that community need and local perspectives are considered in capital decisionmaking; allows hospital management the flexibility to make capital decisions which do not adversely affect access or cost; is cautiously implemented and carefully evaluated to avoid unwanted consequences and to permit corrective action when needed.

Simply put, any approach to Medicare capital payment must have a mechanism for ensuring that the limited dollars available go where they are needed. The debate to date has been focused on institutional efficiency. We agree with the need for such efficiency

but also believe that the real issue in capital policy should be the efficiency of the total health care system and its responsiveness to a community's need for health services.

I would just note in closing that in enacting the prospective payment system for operating costs in 1983, Congress recognized the need to revitalize the professional review organizations as an essential check-and-balance on utilization, quality, and cost. It was acknowledged that a mechanism, external to individual hospitals, was needed to offset the perverse incentives created for institutional providers. An equally compeling need exists for an external decisionmaking system for capital decisions.

It is our view that a strong health planning activity can play that role.

Thank you, Mr. Chairman.

[The prepared statement follows:]

AMERICAN HEALTH PLANNING ASSOCIATION

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Executive Director

TESTIMONY PRESENTED

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

BY

DAVID S. ABERNETHY, M.P.H.
PRESIDENT-ELECT
AMERICAN HEALTH PLANNING ASSOCIATION

AND

DEPUTY COMMISSIONER
NEW YORK STATE DEPARTMENT OF HEALTH

FEBRUARY 24, 1986

AHPA/VA Conference—Systems Integration: Compounding The Cubes—Hyatt Regency Baltimore and Sheraton Inner Harbor Hotels—Baltimore, Maryland—December 15-18, 1985
6th Annual Health Policy Conference—The Washington Hilton Hotel—Washington, D.C.—March 4-6, 1986
16th Annual Meeting—Hyatt Regency San Francisco at Embarcadero Center—San Francisco, California—June 30-July 2, 1986
1110 Vermont Avenue, N.W. • Suite 900 • Washington, D.C. 20005 • (202) 863-1200

SUMMARY OF THE AMERICAN HEALTH PLANNING ASSOCIATION
TESTIMONY BEFORE THE SUBCOMMITTEE
ON HEALTH, HOUSE WAYS AND MEANS COMMITTEE
February 24, 1986

- Health Care capital decisions must be responsive to the needs of communities

- For apparent budgetary reasons the administration has proposed limiting Medicare capital costs by incorporating such cost into the DRG rates by regulation.

- If Congress believes there is a need to limit future capital costs, then Congress should set an appropriate limit, but how that limit is applied (the payment method) will effect the size and distribution of health care services for years to come.

- There are essentially three basic payment options for capital with several variations. They affect the health care delivery system in different ways.

  - Cost based reimbursement
  - The inclusion of capital for fixed assets or movable equipment in DRG rates
  - The establishment of capital limits or pooling within which capital would be allocated to institutions

- The health care system as a whole is overcapitalized, but individual institutions are in many cases undercapitalized. This suggests that when it comes to capital investment decisions, all health care institutions are not created equal. The capital payment policy must reflect this fact or we risk doing great damage to the availability of essential health services.

- The amount of capacity needed by the hospital system is shrinking due to the introduction of prospective payment and the growth of HMOs. Although a fixed add-on to DRG rates is administratively simple, it cannot target reductions in capacity. The capital payment policy enacted should provide for managed shrinkage across the health care system as a whole in order to ensure that limited health care resources are used as effectively as possible.

- In enacting the DRG system in 1983 the Congress recognized the need to revitalize the Professional Review Organizations as an essential check and balance on utilization, quality, and cost. It was acknowledged that a mechanism, external to hospitals, was needed to off-set the perverse incentives created for institutional providers. An equally compelling need exists for external decision making systems for capital decisions.

- If Congress decides to incorporate capital into the DRG rates, or to allow the administration to do so by regulation, it must, at a minimum, grant states the flexibility to obtain waivers to allocate capital more effectively to needed institutions.

TESTIMONY OF
David S. Abernethy, M.P.H.

President-Elect
American Health Planning Association

Before the SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

February 24, 1986

CHAIRMAN STARK, MEMBERS OF THE SUBCOMMITTEE:

Thank you for providing the American Health Planning Association an opportunity to present our views on Medicare payment for capital costs. I am David Abernethy, President-Elect of AHPA, and Deputy Commissioner for Planning, Policy and Resource Development, New York State Department of Health. I was chairman of the AHPA Commission on Capital Policy, a group of distinguished experts which examined, in detail, the potential effects of various capital payment options on the health care system. I have brought copies with me today and urge you to review this careful analysis of the capital issue. To my knowledge, ours is the only effort to look at the effect of capital payment on the total health care delivery system, and the communities it affects. All other groups have focused only on the potential effects on providers.

It is our firmly held conviction that health care capital decisions must be responsive to the needs of communities. Capital policy, given its central role in shaping the health care system, must reflect that requirement.

I have attached to my testimony evidence that clearly demonstrates that there is great variability in capital costs. For this reason a fixed capital payment per admission will inadvertently reward some, while penalizing other, institutions. These rewards and penalties bear little or no relationship to a

community's need. For example, a fixed capital payment of 7% will produce a 15.5% shortfall in 1991 for the Columbia-Presbyterian Hospital of New York City. Mount Sinai Hospital will experience a 14% shortfall. We urge Congress to carefully consider these facts.

Capital investment decisions represent the best opportunity to shape the health care delivery system of the future. Please keep in mind that capital expenditures, once made, cannot be easily adjusted. The amount of capacity needed by the hospital system is shrinking due to the introduction of the prospective payment system and the growth of HMOs and other managed health care systems. Although a fixed add-on is simple, it cannot target reductions in capacity. We need to manage the shrinkage across the health care system as a whole in order to ensure that limited health care resources are used as effectively as possible.

AHPA urges that Congress develop a comprehensive capital policy which:

- is not limited to Medicare;
- has as a major component a federal payment policy which inhibits overbuilding, improves distribution, and takes into account the needs of hospitals serving the indigent;
- provides support for a stable and adequately funded state and local health planning system to ensure that community need and local perspectives are considered in capital decisionmaking;

- has incentives for phasing out facilities and services which are no longer needed;
- ensures that needed institutions and services have access to stable and predictable sources of capital;
- allows hospital management the flexibility to make capital decisions which do not adversely affect access or cost;
- permits the evaluation of new technologies in clinical settings and pays for such technologies once shown to improve outcomes or reduce costs;
- is cautiously implemented and carefully evaluated to avoid unwanted consequences and permit corrective action when needed.

Simply put, any approach to Medicare capital payment must have a mechanism for ensuring that the limited dollars available go where they are needed. The debate to date has been focused on institutional efficiency. We agree with the need for such efficiency, but also believe that the real issue in capital policy should be the efficiency of the total health care system and its responsiveness to a community's need for health services.

In enacting the prospective payment system for operating costs in 1983, the Congress recognized the need to revitalize the Professional Review Organizations as an essential check and a balance on utilization, quality, and cost. It was acknowledged that a mechanism, external to individual hospitals, was needed to off-set the perverse incentives created for institutional providers.

An equally compelling need exists for an external decision making systems for capital decisions. A strong health planning activity can play that role.

Health planning has always had the unenviable mission of attempting to balance cost containment with the need for access to services. Even with shortcomings, it offers a process which can be an important component of Medicare policy. Health planning is the only remaining federally supported activity which seeks to achieve a balance for access.

The Commission which I chaired attempted to examine all of the basic capital payment options. In doing so, we focused on the effect each option would have on the receipt of health care by people. Keeping this in mind, I would like to comment on the advantages and disadvantages of each of the approaches we indentified.

A. Inclusion of Capital Costs in the DRG Rates

Prospective allowance systems of payment for capital may take a variety of forms. The option discussed most frequently is a fixed payment per admission, based upon national mean historical capital costs. The administration's FY 1987 budget proposal is to develop such a system by regulation. We think that is bad policy.

A capital allowance promises the greatest potential for controlling costs within a single institution. Because this approach removes many incentives in the existing system to overuse capital, the allowance approach provides incentives for hospitals to build at the lowest possible price and interest rates. For these positive reasons the Commission I chaired recommended that movable

equipment costs should be incorporated into the DRG rates.

We did not favor the cost of fixed assets being added to a prospective allowance system because of its negative influence on the availability of services and on access to services. An allowance system poses the biggest threat to availability and access, as it does not take into account either those hospitals with high capital costs due to recently completed construction projec or those hospitals which have low capital costs because they have made no recen capital expenditures. These variations, which an add-on approach cannot adequa address, are not a function of efficient versus inefficient hospitals. Some hospitals, clearly needed by any definition, which had not made major capital i vestments in decades, have now made commitments to revitalize their physical pl to continue to deliver care in their communities. But it will cost money that not be recognized in a simplistic formula approach.

Thus, without extensive transition provisions, and careful design, a capit allowance could have a calamitous outcome for some hospitals, without large sav for the total system. FOR THIS REASON, IF CONGRESS DECIDES TO INCORPORATE CAPI INTO THE DRG RATES, IT MUST, AT A MINIMUM, GRANT STATES THE FLEXIBILITY TO OBTA WAIVERS TO ALLOCATE CAPITAL MORE EFFECTIVELY TO NEEDED INSTITUTIONS.

B. Continuation of the Current Cost-Based Payment System

Under this option, Medicare would continue to reimburse for capital on a

retrospective cost basis, with proposed capital expenditures reviewed by local and state health planning agencies prior to the time a capital expenditure is made.

I include in this option an assumption of state capital expenditure reviews as a prerequisite. Without such reviews, continued cost based reimbursement is not a feasible or affordable option. With a streamlined and adequately funded capital expenditure review program, it is both a feasible and affordable approach.

For the first time in ten years we now have real data on the effect of eliminating capital expenditure reviews and restraints. Two states, Arizona and Utah, deregulated and eliminated capital expenditure reviews in early 1985 and late 1984, respectively. The results have been dramatic.

A recent study, "A Study of The Impact of Deregulation on Health Facilities in Arizona," prepared by the Arizona Department of Health Services provides the most comprehensive picture of the effects of combining cost based reimbursement with no regulatory restraint. In the period of deregulation--forty-one months for nursing homes and eight months for hospitals--Arizona has experienced unprecedented growth in health care facilities and steady increases in hospital and nursing home revenues.

Although I recommend that you review this study and be aware of the impact on nursing home costs, I will limit my comments today to what Arizona has experienced with hospitals. At the point of deregulation in March 1985, Arizona had 72 licensed nonfederal hospitals, operating at a statewide occupancy rate of 56.8%. In the eight months following deregulation, the state received 72 building permit

applications for proposed hospital projects totaling $256 million. This includes 11 new hospitals and 1,640 new beds.

A cost reimbursement system with a strong capital expenditure review does have positive attributes. If one is concerned about the efficiency of the total hospital delivery system, as opposed to internal efficiency within a hospital, the cost reimbursement system with capital expenditure review provides a vehicle to increase the overall efficiency of the total system. It also gives states the ability to encourage capital expenditures for facilities serving high need populations.

C. Pooling of Capital Payments/Establishment of Limits on Capital

The effects of the pooling capital reimbursement and the establishment of explicit limits upon the amount of new capital which can be consumed would be very similar. For this reason, they are discussed together.

Pooling is a system in which all capital payments in a region or state would be paid into a capital reimbursement pool. Capital would then be distributed by state or regional authority to individual hospitals based upon their ability to compete effectively to provide those services deemed by the authority to be needed. The existing structure of state and local health planning could be used as the base to develop such a system.

Under the capital limits option, a fixed limit could be placed on the total dollar value of certificates of need to be granted by review agencies. In both options, the amount of capital expended could be based on the amount which would otherwise be available under the current payment system or under a fixed allow-

ance system.

The strongest argument in favor of these two options is that they have the theoretical ability to shrink the overall capacity of the system more than either of the other two options. Although they provide less incentive to individual hospital managers to shrink capacity within an institution, selection of either of these two options would allow the state or regional review authority to decide specifically which institutions should grow and which should not. It is also true that given the ability of these two options to limit capacity, they have the greatest potential for discouraging admissions increases. Moreover, unlike the other two options, these do not add to the incentive present under the DRG prospective payment system to increase admissions.

Another attractive feature of both the pooling option and the capital limit option is the effect on the cost of capital. Use of either of these options would reduce the cost of capital through reducing risk. In the case of the pool, access to reimbursement from the pool would be guaranteed by the decision to allow the institution to make the capital investment. In the case of the fixed limit, reimbursement would essentially be guaranteed once a share of the fixed limit had been allocated to that particular institution. Further, the competition for limited capital dollars induced by these two options would tend to increase the proportion of capital investments funded through equity as opposed to debt.

As you examine the payment options and their potential effects I urge you to keep in mind a very important fact which kept surfacing in our Commission's deliberations. THE HEALTH CARE SYSTEM AS A WHOLE IS OVER CAPITALIZED, BUT INDIVIDUAL INSTITUTIONS ARE IN MANY CASES UNDERCAPITALIZED. This suggests to me that when it comes to capital investment decisions health care institutions are not created

equal. Capital policy must reflect this fact or else we risk doing great damage to the availability of essential health services.

This observation leads to the conclusion that whatever payment policy adopted must be carefully designed to ensure it does not underpay needed institutions, overpay unneeded institutions, or increase unnecessary capacity. The regulatory approach proposed by the administration does not meet this critical test.

I strongly believe capital should be allocated through a mechanism which targets limited dollars for capital to projects needed by the community. Such a capital policy will assure that capital payments are reasonably consistent with need.

Thank you.

-Feb-86

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

PCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
0000	ARNOLD GREGORY MEMOR	4.08%	3.85%	4.08%	3.85%
7000	BERTRAND CHAFFEE HOS	3.09%	2.79%	3.09%	2.79%
0000	BROOKS MEMORIAL HOSP	10.94%	9.86%	10.94%	9.86%
0000	BUFFALO COLUMBUS HOS	3.78%	3.64%	3.78%	3.64%
0000	BUFFALO GENERAL HOSP	24.84%	19.89%	24.84%	19.89%
0001	CHILDREN'S HOSP (BUF	8.08%	8.09%	8.08%	8.09%
0002	CUBA MEMORIAL HOSPIT	6.95%	6.58%	6.95%	6.58%
0000	DEGRAFF MEMORIAL HOS	8.85%	8.13%	8.85%	8.13%
0000	ERIE COUNTY MEDICAL	14.58%	12.72%	14.58%	12.72%
0085	GENESEE MEMORIAL HOS	10.32%	9.36%	10.32%	9.36%
0000	INTER-COMMUNITY MEMO	3.07%	2.98%	3.07%	2.98%
0000	JAMESTOWN GENERAL HO	14.43%	12.61%	14.43%	12.61%
0000	KENMORE MERCY HOSPIT	5.08%	4.83%	5.08%	4.83%
0000	LAFAYETTE GENERAL HO	1.96%	1.92%	1.96%	1.92%
0007	LAKE SHORE HOSPITAL	7.08%	7.31%	7.08%	7.31%
0000	LOCKPORT MEMORIAL HO	28.75%	22.33%	28.75%	22.33%
0000	MEDINA MEMORIAL HOSP	5.06%	4.81%	5.06%	4.81%
0000	MEMORIAL HOSP WF&GF	3.98%	3.83%	3.98%	3.83%
0000	MERCY HOSPITAL OF BU	9.25%	8.46%	9.25%	8.46%
0000	MILLARD FILLMORE HOS	9.29%	8.50%	9.29%	8.50%
0000	MOUNT ST. MARY'S	4.89%	4.66%	4.89%	4.66%
0000	NIAGARA FALLS MEMORI	8.12%	7.51%	8.12%	7.51%
0000	OLEAN GENERAL HOSPIT	6.64%	6.23%	6.64%	6.23%
0001	OUR LADY OF VICTORY	12.92%	11.44%	12.92%	11.44%
0000	ROSWELL PARK MEMORIA	5.26%	5.00%	5.26%	5.00%
0010	SAINT FRANCIS OF BUF	5.75%	5.44%	5.75%	5.44%
0011	SALAMANCA HOSPITAL D	8.31%	7.67%	8.31%	7.67%
0000	SHEEHAN MEMORIAL EME	17.78%	15.83%	17.78%	15.83%
0006	SHERIDAN PARK HOSPIT	4.28%	4.83%	4.28%	4.83%
0000	SISTERS OF CHARITY H	7.17%	6.69%	7.17%	6.69%
0013	ST. FRANCIS HOSP. (O	8.21%	7.59%	8.21%	7.59%
0002	ST. JEROME HOSPITAL	10.53%	9.53%	10.53%	9.53%
0001	ST. JOSEPH INTERCOMM	6.55%	6.15%	6.55%	6.15%
0000	TRI-COUNTY MEMORIAL	8.55%	7.87%	8.55%	7.87%
0000	WESTFIELD MEMORIAL H	16.35%	14.85%	16.35%	14.85%
0000	WOMANS CHRISTIAN ASS	7.63%	7.08%	7.63%	7.08%
0001	WYOMING COUNTY COMMU	5.77%	5.46%	5.77%	5.46%
	TOTAL WESTERN				
0000	ARNOT-OGDEN MEMORIAL	6.48%	6.09%	6.48%	6.09%
0000	BETHESDA HOSPITAL	7.24%	6.75%	7.24%	6.75%
0000	CORNING HOSPITAL	4.56%	4.36%	4.56%	4.36%
0000	IRA DAVENPORT MEM. H	3.66%	3.53%	3.66%	3.53%
0000	SCHUYLER HOSPITAL	9.43%	8.62%	9.43%	8.62%
0000	ST JAMES MERCY HOSP.	6.15%	5.88%	6.15%	5.88%
0001	ST JOSEPHS H. ELMIRA	4.92%	4.69%	4.92%	4.69%
	TOTAL FINGERLAKES				
0000	A BARTON HEPBURN HOS	7.10%	6.63%	7.10%	6.63%
0000	ALBERT LINDLEY LEE H	4.07%	3.91%	4.07%	3.91%
0000	AUBURN MEMORIAL HOSP	3.63%	3.60%	3.63%	3.60%
0000	CANTON-POTSDAM HOSP.	5.70%	5.39%	5.70%	5.39%
0000	CARTHAGE AREA HOSPIT	7.78%	7.22%	7.78%	7.22%
0001	CHILDERNS HOSPITAL &	8.82%	8.10%	8.82%	8.10%
0000	CLIFTON-FINE HOSP.	6.95%	6.49%	6.95%	6.49%
0000	COMM. MEM. HOSP.-MAD	12.18%	10.86%	14.36%	14.86%
0000	COMMUNITY-GENERAL HO	8.36%	7.72%	8.36%	7.72%
0000	CORTLAND MEMORIAL HO	9.53%	8.70%	9.53%	8.70%
0000	CROUSE-IRVING MEM. H	10.84%	9.78%	15.86%	13.09%
0000	E.J. NOBLE-GOUVERNEU	7.85%	7.28%	7.85%	7.28%
0000	EDWARD JOHN NOBLE (A	7.84%	7.27%	7.84%	7.27%
0000	FAXTON HOSPITAL	17.12%	14.62%	17.12%	14.62%
0001	HOUSE OF GOOD SAMARI	9.23%	8.45%	9.23%	8.45%
0000	LEWIS CO. GEN. HOSP.	7.18%	6.70%	7.18%	6.70%
0000	LITTLE FALLS HOSP.	7.81%	7.04%	7.81%	7.04%
0000	MASSENA MEM. HOSP.	4.12%	3.96%	4.12%	3.96%

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OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
2201001	MERCY HOSP. OF WATER	9.78%	8.84%	9.78%	8.84%
2101000	MOHAWK VALLEY GEN HO	7.19%	6.71%	7.19%	6.71%
2601000	ONEIDA CITY HOSPITAL	6.10%	5.75%	6.10%	5.75%
3702000	OSWEGO HOSPITAL	2.07%	2.01%	2.07%	2.01%
3201000	ROME HOSP. & MURPHY	5.12%	5.77%	6.12%	5.77%
3202002	ST ELIZABETH UTICA	11.26%	10.12%	11.26%	10.12%
3301003	ST JOSEPHS HOSP HEAL	5.36%	5.08%	5.36%	5.08%
3202003	ST LUKES MEM. HOSP.	10.23%	9.28%	10.23%	9.28%
3301007	STATE UNIVERSITY UPS	6.93%	6.48%	6.93%	6.48%
3401001	TOMPKINS CO. HOSPITA	14.30%	12.51%	14.30%	12.51%
	TOTAL CENTRAL				
0824000	CHENANGO MEMORIAL H.	5.25%	4.99%	5.25%	4.99%
0301001	OUR LADY OF LOURDES	7.24%	6.73%	7.24%	6.73%
5320000	TIOGA GENERAL HOSP.	10.13%	9.28%	10.13%	9.28%
0303001	UNITED HEALTH SERVIC	10.33%	9.36%	10.33%	9.36%
	TOTAL NY PENN				
1221000	A.L. & O.B. O'CONNOR	3.16%	3.07%	3.16%	3.07%
4521000	ADIRONDACK REGIONAL	3.49%	3.21%	3.49%	3.21%
0101000	ALBANY MEDICAL CENTE	6.91%	6.46%	6.91%	6.46%
1624000	ALICE HYDE MEMORIAL	4.37%	4.19%	4.37%	4.19%
2801000	AMSTERDAM MEMORIAL H	5.35%	5.08%	13.31%	11.73%
3801000	AURELIA OSBORN FOX H	9.88%	8.99%	9.88%	8.99%
4652000	BELLEVUE MATERNITY H	12.63%	11.21%	12.63%	11.21%
0901001	CHAMPLAIN VALLEY PHY	6.38%	5.52%	6.38%	5.52%
0101002	CHILD'S HOSPITAL	11.05%	9.95%	11.05%	9.95%
0102000	CONOES MEMORIAL HOSP	8.13%	7.52%	8.13%	7.52%
1001000	COLUMBIA MEMORIAL HO	6.24%	5.87%	6.24%	5.87%
4720000	COMMUNITY - SCHOHARI	13.24%	11.69%	13.24%	11.69%
1225000	COMMUNITY HOSP (STAM	5.72%	5.41%	5.72%	5.41%
1229000	DELAWARE VALLEY HOSP	27.99%	21.87%	27.99%	21.87%
1521000	ELIZABETHTOWN COMMUN	13.61%	11.98%	13.61%	11.98%
4601001	ELLIS HOSPITAL	8.84%	8.12%	8.84%	8.12%
5725000	EMMA LAING STEVENS H	11.38%	10.32%	11.38%	10.32%
1623000	GENERAL-SARANAC LAKE	3.88%	3.66%	3.88%	3.66%
5601000	GLENS FALLS HOSPITAL	12.24%	10.98%	12.24%	10.98%
1702000	JOHNSTOWN HOSPITAL	5.74%	5.43%	5.74%	5.43%
4161000	LEONARD HOSPITAL	5.91%	5.58%	5.91%	5.58%
3824000	M.I. BASSETT HOSP.	6.21%	5.85%	6.21%	5.85%
1226000	MARGARETVILLE MEMORI	10.35%	9.38%	10.35%	9.38%
5721000	MARY MC'CLELLAN HOSP	11.82%	10.57%	11.82%	10.57%
0101003	MEMORIAL HOSP. (ALBA	14.17%	12.41%	14.17%	12.41%
1921000	MEMORIAL OF GREENE C	7.41%	6.98%	7.41%	6.98%
1527000	MOSES-LUDINGTON HOSP	37.97%	27.52%	37.97%	27.52%
1701000	NATHAN LITTAUER HOSP	15.13%	13.14%	15.13%	13.14%
1523000	PLACID MEMORIAL HOSP	6.67%	6.25%	6.67%	6.25%
4102002	SAMARITAN H. OF TROY	6.97%	6.51%	6.97%	6.51%
4501000	SARATOGA HOSPITAL	23.28%	18.88%	23.28%	18.88%
4601002	ST CLARES SCHENECTAD	8.08%	7.41%	8.08%	7.41%
4102001	ST MARYS H. OF TROY	17.11%	14.61%	17.11%	14.61%
2801001	ST MARYS OF AMSTERDA	16.88%	14.39%	16.88%	14.39%
0101004	ST PETERS HOSPITAL	10.31%	9.51%	10.31%	9.51%
4601004	SUNNYVIEW HOSP. & RE	4.36%	4.18%	4.36%	4.18%
1227000	THE HOSPITAL	3.59%	3.46%	3.59%	3.46%
	TOTAL NORHTEAST				
3523000	ARDEN HILL HOSPITAL	9.17%	8.48%	9.17%	8.48%
5501000	BENEDICTINE HOSPITAL	14.06%	12.32%	14.06%	12.32%
5957000	BLYTHDALE	3.18%	3.01%	3.18%	3.01%
5902002	BURKE REHABILITATION	6.68%	6.09%	6.68%	6.09%
5263000	COMMUNITY GEN. O MAR	15.37%	13.32%	15.37%	13.32%
5253000	COMMUNITY GEN. O MER	4.79%	4.57%	4.79%	4.57%

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ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
3522000	CORNWALL HOSPITAL	11.50%	10.37%	11.50%	10.37%
3525000	DOBBS FERRY HOSPITAL	7.18%	6.70%	7.18%	6.70%
3526001	ELLENVILLE COMMUNITY	5.94%	5.61%	5.94%	5.61%
4329000	GOOD SAMARITAN SUFFN	42.63%	23.98%	42.63%	23.98%
4322000	HELEN HAYES HOSPITAL	21.68%	17.76%	21.68%	17.76%
1301000	HIGHLAND HOSP BEACON	5.49%	6.59%	5.49%	6.59%
3501000	HORTON MEMORIAL HOSP	15.88%	13.64%	15.88%	13.64%
3520000	JULIA L. BUTTERFIELD	6.01%	5.67%	6.01%	5.67%
4501001	KINGSTON HOSPITAL	5.67%	5.35%	13.74%	12.88%
3522000	LAWRENCE HOSPITAL, I	9.77%	8.98%	5.77%	8.98%
3535001	MERCY COMMUNITY HOSP	33.07%	24.86%	ERR	ERR
3503000	MOUNT VERNON HOSPITA	8.68%	7.99%	8.68%	7.99%
3504000	NEW ROCHELLE HOSPITA	16.31%	14.82%	16.31%	14.82%
1327000	NORTHERN DUTCHESS HO	12.28%	10.94%	12.28%	10.94%
3520000	NORTHERN WESTCHESTER	11.95%	10.67%	11.95%	10.67%
3505001	NY HOSP CORNELL	2.63%	2.57%	2.63%	2.57%
4324000	NYACK HOSPITAL	22.93%	18.65%	22.93%	18.65%
4501000	PEEKSKILL HOSPITAL	10.76%	9.72%	10.76%	9.72%
3532000	PHELPS MEMORIAL HOSP	6.61%	6.28%	6.61%	6.28%
3950000	PUTNAM COMMUNITY HOS	11.19%	10.06%	11.19%	10.06%
3954000	ST VINCENTS-WESTCHES	5.73%	5.42%	5.73%	5.42%
5902000	ST. AGNES HOSPITAL	12.47%	11.09%	12.47%	11.09%
3529000	ST. ANTHONY COMMUNIT	14.07%	12.34%	14.07%	12.34%
1302000	ST. FRANCIS(POUGHKEE	25.38%	20.24%	25.38%	20.24%
5907001	ST. JOHN'S RIVERSIDE	13.24%	11.69%	23.29%	18.09%
5907002	ST. JOSEPH'S MEDICAL	17.87%	15.16%	17.87%	15.16%
3502000	ST. LUKE'S OF NEWBUR	11.75%	10.52%	11.73%	10.52%
4353000	SUMMIT PARK-ROCK. IN	8.85%	7.45%	8.85%	7.45%
3536000	TUXEDO MEMORIAL HOSP	3.78%	3.65%	3.78%	3.65%
5906000	UNITED HOSPITAL	12.43%	11.05%	12.43%	11.05%
1302001	VASSAR BROTHERS HOSP	12.11%	10.88%	12.11%	10.88%
5957001	WESTCHESTER COUNTY	16.86%	13.84%	16.86%	13.84%
5902001	WHITE PLAINS HOSPITA	8.32%	7.68%	8.32%	7.68%
5907003	YONKERS GENERAL HOSP	10.82%	9.11%	10.82%	9.11%
	TOTAL HUDSON VALLEY				
7003015	ASTORIA GENERAL HOSP	8.28%	7.65%	8.28%	7.65%
7001026	BAPTIST MEDICAL CENT	3.57%	3.45%	3.57%	3.45%
7004006	BAYLEY SETON HOSPITA	37.66%	27.36%	37.66%	27.36%
7002001	BELLEVUE HOSPITAL CT	7.10%	6.63%	7.10%	6.63%
7002002	BETH ISRAEL MEDICAL	10.73%	9.69%	10.73%	9.69%
7003010	BOOTH MEMORIAL MEDIC	10.93%	9.86%	10.93%	9.86%
7000002	BRONX MUNICIPAL HOSP	3.44%	3.32%	3.44%	3.32%
7000001	BRONX-LEBANON HOSPIT	8.29%	7.65%	8.29%	7.65%
7001002	BROOKDALE HOSP. MED.	4.14%	3.98%	4.14%	3.98%
7001003	BROOKLYN-CALENDONIAN	14.36%	12.71%	19.19%	16.87%
7002003	CABRINI HEALTH CARE	9.35%	8.72%	9.35%	8.72%
7000011	CALVARY HOSPITAL, IN	9.46%	8.64%	9.46%	8.64%
7003008	CATHOLIC MEDICAL CEN	18.64%	15.71%	18.64%	15.71%
7001024	CHURCH CHARITY FOUND	11.45%	10.27%	11.45%	10.27%
7003000	CITY HOSPITAL CENTER	3.73%	3.59%	3.73%	3.59%
7002051	COLER MEMORIAL HOSPI	3.78%	3.57%	3.78%	3.57%
7001008	COMMUNITY HOSP.(BROO	19.03%	15.92%	ERR	ERR
7001009	CONEY ISLAND HOSPITA	3.46%	3.35%	3.46%	3.35%
7003017	DEEPDALE GENERAL HOS	4.89%	4.66%	4.89%	4.66%
7004005	DOCTOR'S HOSP. - STA	3.54%	3.42%	3.54%	3.42%
7002004	DOCTORS HOSPITAL, IN	21.91%	17.97%	21.91%	17.97%
7001039	FLATBUSH GENERAL HOS	2.32%	2.27%	2.32%	2.27%
7003001	FLUSHING HOSPITAL	10.32%	9.84%	10.32%	9.84%
7002050	GOLDWATER MEMORIAL H	3.89%	3.73%	3.89%	3.73%
7003013	H.I.P. HOSPITAL, INC	7.31%	6.98%	7.31%	6.98%
7002009	HARLEM HOSPITAL CENT	3.36%	3.44%	3.36%	3.44%
7002012	HOSP. FOR SPECIAL SU	8.53%	7.86%	8.53%	7.86%
7002098	INSTITUTE OF REHAB.	5.09%	4.84%	5.09%	4.84%
7001046	INTERFAITH	4.94%	4.71%	4.94%	4.71%
7003003	JAMAICA HOSPITAL	4.69%	4.48%	4.69%	4.48%
7002052	JOINT DISEASES NORTH	2.86%	2.80%	2.86%	2.80%
7002011	JOINT DISEASES-ORTHO	16.85%	14.42%	16.85%	14.42%

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DPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
7001016	KINGS COUNTY HOSPITA	3.49%	3.37%	3.49%	3.37%
7001041	KINGS HIGHWAY HOSP.	9.66%	8.81%	9.66%	8.81%
7001033	KINGSBROOK JEWISH ME	6.22%	5.86%	6.22%	5.86%
7002017	LENOX HILL HOSPITAL	7.73%	7.18%	7.73%	7.18%
7000000	LINCOLN MEDICAL & ME	15.45%	13.38%	15.45%	13.38%
7001017	LONG ISLAND COLLEGE	18.48%	15.68%	28.68%	22.97%
7003004	LONG ISLAND JEWISH M	13.35%	11.78%	13.35%	11.78%
7001019	LUTHERAN MEDICAL CEN	14.12%	12.37%	14.12%	12.37%
7001020	MAIMONIDES MEDICAL C	8.31%	7.67%	8.31%	7.67%
7002019	MANHATTAN EYE, EARITH	15.78%	13.57%	15.78%	13.57%
7002045	MEDICAL ARTS CENTER	1.46%	1.44%	1.46%	1.44%
7002020	MEMORIAL HOSP. FOR C	4.53%	4.33%	4.53%	4.33%
7001021	METHODIST HOSPITAL	21.47%	17.68%	21.47%	17.68%
7002021	METROPOLITAN HOSPITA	3.76%	3.62%	3.76%	3.62%
7000005	MISERICORDIA HOSPITA	21.58%	17.69%	21.58%	17.69%
7000006	MONTEFIORE HOSPITAL	8.57%	7.89%	18.15%	15.36%
7002024	MOUNT SINAI HOSPITAL	7.94%	7.36%	26.61%	21.82%
7002026	N.Y. EYE & EAR INFIR	3.64%	3.31%	3.64%	3.31%
7002000	N.Y. INFIRMARY - BEE	3.99%	3.84%	3.99%	3.84%
7002029	N.Y. UNIVERSITY MED.	10.63%	9.63%	10.65%	9.63%
7000024	NORTH CENTRAL BRONX	10.16%	9.22%	10.16%	9.22%
7002025	NY HOSP. & PAYNE WHI	16.41%	14.89%	ERR	ERR
7003025	OSTEOPATHIC HOSPITAL	3.78%	3.65%	3.78%	3.65%
7003020	PARKWAY HOSPITAL	4.94%	4.71%	4.94%	4.71%
7003021	PARSONS SANITARIUM,	2.94%	2.85%	2.94%	2.85%
7000019	PELHAM BAY GENERAL H	1.99%	1.95%	1.99%	1.95%
7003006	PENINSULA HOSPITAL C	4.95%	4.72%	4.95%	4.72%
7003022	PHYSICIANS HOSPITAL	1.48%	1.46%	1.48%	1.46%
7002030	PRESBYTERIAN HOSPITA	9.13%	8.38%	29.05%	22.51%
7003007	QUEENS HOSPITAL CENT	3.85%	3.71%	3.85%	3.71%
7004000	RICHMOND MEMORIAL HO	6.93%	6.48%	18.82%	15.84%
7002031	ROCKEFELLER UNIVERSI	1.61%	1.59%	1.61%	1.59%
7000014	ST. BARNABAS HOSPITA	9.50%	8.67%	9.50%	8.67%
7002033	ST. CLARE'S HOSP.& H	2.64%	2.57%	2.64%	2.57%
7002032	ST. LUKE'S-ROOSEVELT	7.31%	6.81%	7.31%	6.81%
7001025	ST. MARY'S OF BROOKL	11.16%	10.04%	11.16%	10.04%
7004001	ST. VINCENT'S (RICHM	8.64%	7.95%	8.64%	7.95%
7002037	ST. VINCENT'S HOSPIT	15.86%	13.89%	19.59%	16.38%
7001037	STATE UNIV. - DOWNST	7.67%	7.13%	7.67%	7.13%
7004003	STATEN ISLAND HOSPIT	14.00%	12.28%	14.00%	12.28%
7000009	UNION HOSPITAL ASSOC	1.46%	1.44%	13.41%	11.82%
7001032	VICTORY MEMORIAL HOS	7.00%	6.54%	22.97%	18.68%
7000023	WESTCHESTER SQUARE H	8.52%	7.85%	8.52%	7.85%
7001045	WOODHULL MED & M. H.	33.55%	25.12%	33.55%	25.12%
7001035	WYCKOFF HEIGHTS HOSP	5.39%	5.11%	5.39%	5.11%
	TOTAL NYC				
5123000	BROOKHAVEN MEMORIAL	5.85%	5.53%	5.85%	5.53%
5120000	BRUNSWICK HOSPITAL C	8.57%	7.89%	8.57%	7.89%
2952002	CENTRAL GENERAL HOSP	5.47%	5.19%	5.47%	5.19%
5135000	CENTRAL SUFFOLK HOSP	19.36%	16.36%	19.36%	16.36%
2901000	COMMUNITY AT GLEN CO	12.42%	11.04%	12.42%	11.04%
5127000	EASTERN LONG ISLAND	10.72%	9.69%	10.72%	9.69%
2910000	FRANKLIN GENERAL HOS	9.88%	8.97%	9.88%	8.97%
5154001	GOOD SAMARITAN-WEST	11.07%	9.97%	11.07%	9.97%
2906000	HEMPSTEAD GENERAL HO	7.43%	6.91%	7.43%	6.91%
5153000	HUNTINGTON HOSP. ASS	9.22%	8.44%	9.22%	8.44%
5149000	JOHN T. MATHER MEMOR	16.44%	14.12%	16.44%	14.12%
2902000	LONG BEACH MEMORIAL	7.76%	7.08%	27.96%	21.85%
2904000	LYDIA E. HALL HOSPIT	7.57%	7.04%	7.57%	7.04%
2950000	MASSAPEQUA GENERAL H	4.78%	4.69%	4.78%	4.69%
2909000	MERCY HOSP. ASSOCIAT	9.78%	8.86%	9.78%	8.86%
2952001	MID-ISLAND HOSPITAL	1.54%	1.52%	1.54%	1.52%
2950002	NASSAU COUNTY MEDICA	10.77%	9.72%	10.77%	9.72%
2900000	NASSAU HOSPITAL, GEOR	7.00%	6.55%	7.00%	6.55%
2951001	NORTH SHORE UNIVERSI	10.04%	9.12%	10.04%	9.12%
5157001	SMITHTOWN GENERAL HO	8.39%	7.66%	8.39%	7.66%
2950001	SOUTH NASSAU COMMUNI	11.62%	10.41%	11.62%	10.41%

14-Feb-86

ESTIMATED 1986 CAPITAL AS A PERCENTAGE OF REVENUE

OPCERT	HOSPITAL NAME	TOTAL CAPITAL AS A PERCENT OF OPERATING	TOTAL CAPITAL AS A PERCENT OF TOTAL REVENUE	TOTAL CAPITAL & CONSTRUC. AS A PERCENT OPERATING	TOTAL CAPITAL & CONSTRUC. AS A PERCENT TOTAL REVENUE
5125000	SOUTHAMPTON HOSP. AS	6.99%	6.54%	6.99%	6.54%
5154000	SOUTHSIDE HOSPITAL	7.45%	6.93%	7.45%	6.93%
5149001	ST. CHARLES HOSPITAL	5.44%	5.16%	5.44%	5.16%
5953000	ST. FRANCIS HOSP. (RO	9.35%	8.55%	9.35%	8.55%
5151001	STATE UNIV. @ STONY	43.00%	38.07%	43.00%	38.07%
	TOTAL NASSAU-SUFFOLK				
	STATEWIDE TOTALS:				
	WESTERN	11.31%	10.16%	11.31%	10.16%
	FINGERLAKES	5.81%	5.49%	5.81%	5.49%
	CENTRAL	8.41%	7.76%	9.21%	8.43%
	NY PENN	9.83%	8.28%	9.83%	8.28%
	NORTHEAST	9.54%	8.71%	9.67%	8.82%
	HUDSON VALLEY	14.22%	12.45%	14.82%	12.98%
	NEW YORK CITY	9.21%	8.44%	12.00%	10.71%
	NASSAU-SUFFOLK	10.55%	9.55%	10.96%	9.88%
	STATEWIDE TOTALS:	9.91%	9.01%	11.73%	10.58%

Chairman STARK. You are welcome.

Mr. Abernethy, following your suggestion, wouldn't we basically, if we were to enact what you propose, get into some kind of a national health system?

Mr. ABERNETHY. Is what I propose—would that get us into a national health system?

Chairman STARK. Isn't that the direction you want?

Mr. ABERNETHY. I don't believe so.

Chairman STARK. You think we could accomplish it the way we are structured now as between Medicare and Medicaid and private health insurance and military health systems and the veterans hospitals, do you think all of that could continue to function with its territorial jealousies and in the absence of an overall national health policy?

Mr. ABERNETHY. I think we have been trying to reach a national health policy for a number of years and haven't made it. Being a pragmatic person, I accept the notion that we are not going to for a period of time. Since we are talking about delivering health services to people, it is reasonable that in making decisions that drive the entire system that communities have an opportunity to have a say in those decisions.

Chairman STARK. I agree with you, but I am at the point where I have listened to free enterprise so long I want to gag on it, so my feeling is to hell with them, let them have it. I will buy medical services like I buy a car. We get a bid and we get a six-cylinder car with automatic transmission and take the best price or you put on gasoline standards and some of them make cars. That is a sad commentary and I would rather continue the discussion along the lines you are, but I think politically that has been foreclosed.

That is my own feeling. That may come in another day under a different set of circumstances, but I think we have to do the best we can here, and I merely just say that as a response to your testimony, which I do appreciate.

I would suspect that I am perhaps in more agreement with you than much of the other testimony we have had here today.

Mr. Byrnes, on your question of old and new, I just did a very quick calculation here and if you presume that most of the capital issued since 1977 is going to come under the new capital, meet the requirements because they didn't really get it on line, that that somehow or other would qualify as new capital and the Medicare share of that might be 60 percent. Have you tried to quantify—I would assume we have $60 billion in capital.

Mr. BYRNES. That is old capital.

Chairman STARK. Do you have any idea how much old capital you think is out there?

Mr. BYRNES. No.

Chairman STARK. I have a hunch that you guys are talking about a figure—if you take into account what the witnesses here today are saying—I thought about it before 1983, it was a glint in my eye, and now that ought to—as you know, the transition rules were used in the tax business—if your brother-in-law thought about it in time, you could get a transition.

Mr. BYRNES. That would be, I think, a very difficult number to come across without a huge data base.

hairman STARK. I would guess 50, 60——
Ir. ABERNETHY. For New York State, it is $900 million worth of nbursement on an annual basis for capital costs. It would cost for the total health care system of one state about $900 million ear.
hairman STARK. Some of that may be going back to pre——
Ir. ABERNETHY. That would be passing through, using the old es. It would cost $900 million, give or take, today.
Ir. BROMBERG. I think rather than trying to find out what the nber is, we should focus on how to do it. We want this to be lget neutral.
hairman STARK. No; the administration doesn't want this to be lget neutral. If you believe that, you think pigs have wings.
Ir. BROMBERG. How much capital reimbursement was being laid by Medicare, the answer is $3.2 billion. You can't payout the 2 billion and give everybody 7 percent or an add-on on top of t, so what you would have to do is proportion the two numbers. u would say we are going to project the $3.2 billion and try to y the 7 percent, but in order to make both budget neutral, we e going to figure out what portion of the capital 2, 4, and 5 years m now is old and we will pay that at the $2 billion level and at part is new——
Chairman STARK. What if you said pay the old and no more new d wait until the system squeaks so loud from lack of reimbursent for new, keep the DRG's where they are, keep the old until it pires, and see what happens in a few years, as opposed to a eeze?
Mr. BROMBERG. You would be penalizing the hospitals 30 and 40 ars old who are at 2 and 3 percent and need to spend capital. ou would be doing worse than freezing it. We have to have owth in the system. I tend to think that more hospitals could surve longer on that.
Chairman STARK. I am saying the administration is saying if we this the way free enterprise does it, it will work out—if we uble the amount of united giving—what would that do to any of ur hospitals? That would be a drop in the bucket.
Mr. BROMBERG. As you have said, you can't send someone into e marketplace with no money in their pocket and expect them to me out of it.
Chairman STARK. I have a question for you and I am not chalnging this, but this was a question raised by staff. We have been d to believe by the House Legislative Counsel and an opinion om the American Law Division and the CRS that the Secretary oes have the authority to add capital cost to PPS. That may not e the popular route of this committee for the Secretary to follow nd I wonder if you have a legal citation or opinion that would efute the Secretary's authority. We would be interested in seeing t if you do.
Mr. BROMBERG. As soon as we get one. We have ordered it and I lon't know what it will say, but as soon as we get further informaion, I would be glad to share it with you.
Chairman STARK. That obscures the issue, the issue of formulatng a decent policy. If you do, we are under the opinion, at least—Mr. Gradison and I are not attorneys——

Mr. BROMBERG. If I could give you a non-practicing attorney response, the statute as we read it passed in 1983 basically says Congress is going to do something by October 1, 1986, but if we don't, then 1122 must be made mandatory. It seems to be saying that if Congress doesn't legislate what happens is 1122 kicks in. It doesn't say anywhere the Secretary can go out and do anything. The section they seem to be relying on is one that says capital is exempt until October 1986 and they read into it therefore we can do it without a regulation.

Chairman STARK. I don't think they have authority to change 1122 and let that slide off to the side and hope it will change that, but not their approach.

I appreciate you all being here. I think you all sense the frustration of this committee in trying to do what we can. I think if we could handle something that was budget neutral, I suspect that the committee would find, quite frankly—and some of you might be able to address this for us, if you would—the definitional problem of categorizing old and new capital.

Several of you have raised that issue and it has been raised before. We see that as horrendous. For any of you familiar with it, I am sure Mr. Byrnes has an idea of transition rules and bond issues, I think we would find that we would literally come close to writing 6,000 separate definitions for each hospital in the country as to what was old or new capital on a case-by-case basis and we just don't have the time. But if there were some areas that you thought were quick and dirty that we might use, we could certainly use it. Again, while I have said often that I think that postponement is a lousy way to legislate, it may be our only fallback position unless we can come up with something better.

I am sure you are all aware of the budget constraints we are faced with. I believe that the committee wants very much to legislate and not let this go by default. I am not sure that a freeze is that much better a solution for a year than letting the Secretary have his way, and I will let you turn your wrath on the administration for a while rather than on this subcommittee.

Again, I appreciate, in all seriousness, your help.

Mr. Abernethy, I have not had a chance to review your detailed estimates, but it is those kinds of specific cases that help us see if we can find a solution. Any other information you can give us will be much appreciated, and again I apologize for the lateness of the day. Your patience and the patience of our guests is appreciated.

The committee will recess subject to the call of the Chair.

Thank you.

[Whereupon, at 5:15 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT

OF THE

AMERICAN PROTESTANT HEALTH ASSOCIATION

Summary.

1. Legislation Not Regulation.

The Administration's proposal for capital imbursement is designed solely to achieve short-term budget ductions and bears no relationship to rational and sound alth policy. Any changes made in capital reimbursement licy should be made by the Congress through legislation ther than by the Secretary of Health and Human Services rough regulation.

2. One Year Delay.

The Congress should delay any change in Medicare pital reimbursement policy for one year to assess the impact hospitals of other factors affecting capital financing, such tax-exempt bond financing and frozen Medicare operating evenues.

3. Application To New Capital Only.

Any new capital reimbursement methodology should pply only to new capital. Old capital should be grandfathered." Old capital is defined as that obligated (as efined by the Section 1122 regulations at 42 C.F.R. 100.103(c)) prior to April 20, 1983, and for which financing as been completed by October 1, 1986.

4. Necessary Components Of Any New Methodology Where Old Capital Is Not "Grandfathered".

If the Congress should determine a comprehensive rospective capital policy, applying to old capital, three

necessary components include: a minimum ten-year transition period; a weighted blend comprised of national and hospital-specific rates; and rolling bases for both national and hospital-specific base years.

5. Repeal Section 1122.

Section 1122 of the Social Security Act should be repealed.

B. Introduction.

The American Protestant Health Association (APHA) represents 300 hospitals and nursing homes in 39 states, totaling over 60,000 beds. On behalf of our nonprofit membership, we appreciate the opportunity to present our views in this format.

C. Discussion.

1. The Administration's Proposal Should Not Be Adopted And Congress Should Legislate Any New Capital Policy.

The Department of Health and Human Services ("HHS") proposes to restructure the existing system of Medicare capital cost reimbursement to hospitals through regulations. Capital costs are to be included in the Prospective Payment System ("PPS") of Medicare reimbursement beginning with cost accounting periods starting on or after October 1, 1986. The Department contemplates issuing a notice of proposed rulemaking as early as June 1, 1986.

The Administration proposes a national prospective payment for capital which would be phased-in over a four year transition period. During the transition period, payments to hospitals would be based on a combination of a national and

hospital specific rate. The proposal implements a 1983 base year for the national rate and a 1986 base year for the hospital-specific rate. The Administration's proposal is not a sound health policy, but is, instead, based solely on short-term budget savings. It is seriously flawed and probably illegal. HHS is statutorily committed to reimburse capital projects on a reasonable cost basis for capital obligated before April 20, 1983, the date of enactment of the PPS program. The Conference Report to the Social Security Amendments of 1983 refers only to the possibility of changing the capital payment policy for capital obligated after April 20, 1983, and does not consider that capital obligated prior to that date would be subject to a new capital policy. See Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 190 (1983). The Administration is seeking to implement a blended national and hospital-specific rate, which would be less than the hospitals' actual fixed capital expenses. Thus, the amount of capital reimbursement will not cover the hospitals' fixed debts, and many will be forced into default on their bonds.

Further, the Administration recommends using base years to determine the national and hospital-specific rates (1983 and 1986, respectively) which do not account for any capital expenditures obligated prior to April 20, 1983 and not yet on line until 1987 or later. Those costs would not have been reflected in the 1983 and 1986 cost reports and, therefore, are not recognized by the Administration's proposal.

The crucial health policy issues raised by the drastic cut in hospital capital resources flowing from this proposal require that policy be made by the Congress through legislation, and not by the Secretary through regulation.

2. Any Change In Medicare Capital Reimbursement Policy Should Be Delayed For One Year.

The Congress should assess the impact of other factors affecting hospitals' access to capital in order to execute an adequate and equitable capital reimbursement policy. One such factor is the tax-exempt bond legislation under consideration currently in the Senate Finance Committee as part of tax reform. The Tax Reform Act of 1985, H.R. 3838, would severely restrict hospitals' ability to finance new projects using low-interest capital and would limit the access of non-profit hospitals to the capital markets. Indeed, data from the New York State Medical Care Facility Finance Agency indicates that contemplated PPS reimbursement rates would result in an 80% default rate in FHA 242 mortgages. This would occur because capital reimbursement would be insufficient to amortize high interest mortgage loans.

Similarly, Medicare reimbursement for operating revenues has been essentially frozen for at least the next five years by the operation of Gramm-Rudman-Hollings.

Tax-exempt bond restrictions and reduced operating revenues will inevitably restrain the incursion of capital costs. This effect may obviate the need for the inclusion of capital costs in the PPS. At a minimum, the Congress should delay implementation of any new capital methodology for one year in order to evaluate the impact of tax reform and other related legislation upon hospital capital and operating resources.

3. Protection Of Old Capital.

The statutory provisions regarding reimbursement of capital are admittedly complex. The only reasonable

construction of those provisions, however, indicates that all capital obligated prior to April 20, 1983 (the enactment of the PPS) is exempt from the PPS and should be reimbursed on a reasonable cost basis. See Section 1886(a)(4) of the Social Security Act (42 U.S.C. §1395ww(a)(4)). The intent of the Congress to reimburse capital obligated prior to April 20, 1983 on a reasonable cost basis is reaffirmed in the Conference Report to the Social Security Amendments. The Report states that there is no assurance that projects obligated after April 20, 1983 will continue to be paid on a reasonable cost basis. This indicates that capital obligated prior to that date will be reimbursed on a reasonable cost basis regardless of when those capital costs are paid. See Conf. Rep. No. 98-47, 98th Cong., 1st Sess. 190 (1983).

We propose a definition of old capital which would include capital obligated prior to April 20, 1983, and for which financing has been completed by October 1, 1986. Such a definition reflects a compromise and sets clear parameters for that capital which should properly be exempt from the PPS. Thus, we propose that old capital be "grandfathered" in a prospective capital payment policy.

In addition to the legal argument mentioned above to "grandfather" old capital, there are practical and policy considerations which should be considered. The nature of capital expenditures is very different from operating costs. Capital obligations are fixed, long-term costs, while operating expenses are flexible and can be reduced if necessary. Capital obligations made prior to April 20, 1983, for which financing has been completed by October 1, 1986, are fixed, long-term commitments. These costs cannot be reduced to enable hospitals to afford and accommodate reduced reimbursement rates. Instead, hospitals will be forced into default on their bonds.

When these commitments were made, hospital trustees and administrators appropriately relied on the then-existing Medicare reimbursement policy to honor the Medicare portion of these debts. It would be manifestly inequitable if hospitals were denied the Medicare reimbursement obligated for these prior commitments.

4. Necessary Components Of Any New Capital Methodology, Where Old Capital Is Not "Grandfathered".

If the Congress should determine a comprehensive prospective capital policy applying to old capital, certain precepts must be included in order to provide a fair policy and ease the harsh impact of the new reimbursement methodology.

a. Transition.

If prospective payment rates for capital are established, a sufficient transition period must be utilized. We strongly object to the Administration's proposed transition period. Senator Durenberger's bill, S. 2121, lengthens the transition period, but it is still too short. An adequate transition period must necessarily extend for at least ten years. Significantly, an October 25, 1985 draft report to the Congress, prepared by HHS, acknowledged the need for church hospitals to have a ten year transition period. See Modified Recommendation to Incorporate Payments for Capital Into the Medicare Prospective Payment System, Department of Health and Human Services, p. 95 (October 25, 1985).

In ascertaining an appropriate transition rule, the structure of hospitals' capital costs must be fully understood and considered. Capital costs are long-term in nature and follow an extended cycle unique to each hospital. Generally, this capital cycle is 20 years, with a ten year mid-life. A

transition period that is sympathetic to current hospital capital cycles would help ensure that hospital capital financing programs are not subject to serious disruption substantially jeopardizing a hospital's ability to make required capital improvements and to continue to provide high quality of care to Medicare beneficiaries.

b. Weighted Blend.

We consider S. 2121, introduced by Senators Durenberger and Quayle, to be a reasonable starting point for the debate on an appropriate capital policy. We clearly prefer a weighted hospital-specific and national rate blend during the transition period. We believe, however, that the seven-year transition to a national rate for capital costs, prescribed in the bill, is too short to provide hospitals with adequate protection. Thus, we recommend a transition period of at least ten years, comprised of a weighted hospital-specific and national blend.

c. Rolling Base.

It is the recommendation of APHA that no fixed base year be used, but that a rolling base of the prior year's cost report be implemented for both the hospital-specific and national rates. This will ensure that capital reimbursement will more accurately reflect current levels.

7. Section 1122 Should Be Repealed.

Absent legislation by the Congress, Section 1886(g)(1) of the Social Security Act will make Section 1122 of that Act mandatory. The mandatory Section 1122 would require states to review providers' capital expenditures. Section 1122

should be repealed. Such a Congressional mandate to the States to review hospitals' capital decisions is unworkable and anti-competitive. The marketplace should govern whether hospital facilities should be constructed or renovated.

If the Congress choses not to repeal the mandatory Section 1122 program, it should enact legislation to require that the Secretary receive notice of disapproval from a state before capital expenditures are disallowed. The States should not be forced to affirmatively recommend approval of a project, particularly since only 15 states currently have a Section 1122 mechanism to review capital expenditures (Arkansas, Delaware, Georgia, Idaho, Iowa, Kentucky, Louisiana, Maine, Minnesota, New Jersey, New Mexico, Oklahoma and West Virginia).

D. Conclusion.

APHA believes that capital payments must be adequate and equitable in order to prevent the disruption and potential collapse of hospitals and, thus, capital financing mechanisms. The Administration's proposal is devoid of any health policy considerations, reflecting only the short-sighted objective of budget reductions. Accordingly, APHA proposes that the Congress immediately rescind the Administration's regulatory authority to implement a prospective capital methodology. Further, the Congress should delay any revision of Medicare's capital policy until October 1, 1987, to allow consideration of the impact on Medicare capital policy of any tax reform legislation and Gramm-Rudman-Hollings.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Summary of AAMC Recommendations

I. Capital Costs in Major Teaching Hospitals

1. HISTORICAL DATA WHICH COMPARES CAPITAL TO TOTAL EXPENSES HAVE BEEN MISINTERPRETED BY SOME TO IMPLY THAT MAJOR TEACHING HOSPITALS HAVE LOWER ABSOLUTE CAPITAL COSTS THAN OTHER HOSPITALS.

2. CAPITAL COSTS PER UNIT OF WORKLOAD PERFORMED ARE HIGHER IN MAJOR TEACHING THAN OTHER HOSPITALS.

3. MAJOR TEACHING HOSPITALS HAVE OLDER PLANTS THAN OTHER HOSPITALS.

4. RECENTLY INCREASED CAPITAL SPENDING BY MAJOR TEACHING HOSPITALS MAY ALTER STATISTICAL RELATIONSHIPS THAT EXISTED IN DATA COLLECTED IN THE 1970'S AND EARLY 1980.

II. AAMC Principles on Capital Payment

1. THE AAMC SUPPORTS REPLACING INSTITUTIONALLY SPECIFIC, COST BASED RETROSPECTIVE PAYMENTS FOR CAPITAL WITH PROSPECTIVELY SPECIFIED CAPITAL PAYMENTS.

2. THE AAMC SUPPORTS SEPARATING CAPITAL COSTS INTO TWO COMPONENTS -- (1) MOVABLE EQUIPMENT AND (2) FIXED EQUIPMENT AND PLANT.

3. THE AAMC SUPPORTS INCORPORATING CAPITAL PAYMENTS FOR MOVABLE EQUIPMENT INTO PROSPECTIVE PAYMENT USING A PERCENTAGE "ADD-ON" TO PER CASE PAYMENTS.

4. THE AAMC SUPPORTS A PERCENTAGE ADD-ON TO PER CASE PRICES FOR CAPITAL COSTS OF FIXED EQUIPMENT AND PLANT THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT PROVIDED THAT THE ADD-ON IS BASED UPON A PER CASE PRICE WHICH APPROPRIATELY COMPENSATES TERTIARY CARE/TEACHING HOSPITALS FOR THEIR DISTINCTIVE COSTS.

5. THE AAMC SUPPORTS A LONG-TERM, HOSPITAL-SPECIFIC TRANSITION FROM THE CAPITAL PASSTHROUGH TO PROSPECTIVE PAYMENTS FOR PLANT AND FIXED EQUIPMENT.

6. THE AAMC SUPPORTS A TRANSITION PERIOD FOR PLANT AND FIXED EQUIPMENT WHICH ALLOWS EACH HOSPITAL ITS CHOICE OF (1) COST REIMBURSEMENT FOR DEPRECIATION AND INTEREST ON ADJUSTED BASE PERIOD CAPITAL OR (2) A PROSPECTIVE PERCENTAGE ADD-ON THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT.

III. The Administration's Proposal

1. THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS THAT THIS SUBCOMMITTEE ADOPT LEGISLATION PROHIBITING THE SECRETARY OF HHS FROM MAKING CHANGES IN THE PRESENT CAPITAL PASSTHROUGH UNTIL CONGRESS ENACTS LEGISLATION DIRECTING THE SECRETARY TO IMPLEMENT A SPECIFIC CAPITAL PAYMENT METHODOLOGY.

2. THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE FEDERAL COMPONENT FOR COMPUTING CAPITAL PAYMENTS FOR A PHASE-IN TRANSITION SHOULD BE BASED UPON ACTUAL 1986 MEDICAL CAPITAL PAYMENTS UPDATED ANNUALLY FOR INCREASED CONSTRUCTION AND BORROWING COSTS.

3. THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE HOSPITAL-SPECIFIC COMPONENT FOR COMPUTING CAPITAL FOR A PHASE-IN TRANSITIONS SHOULD BE BASED UPON EACH HOSPITAL'S ACTUAL CAPITAL COSTS FOR THAT CURRENT YEAR.

The Association of American Medical Colleges, AAMC, which represents all of the nation's medical schools, 82 academic societies, and over 350 major teaching hospitals participating in the Medicare program, is vitally interested in proposals to change Medicare payment for hospital capital. As this subcommittee knows, the AAMC supported the concept of replacing cost reimbursement for hospital operating costs with a prospective pricing system. Since the enactment of that system, the AAMC has repeatedly appeared before this subcommittee to recommend refinements in the prospective pricing system which would more fully recognize legitimate differences in the costs of different hospitals. Some of those refinements have been made; others are still being debated. In this situation, where payments for basic operating costs do not fully reflect real differences in hospital costs, the AAMC recommends that any new payment system for hospital capital be approached with care and study. A new capital payment system must not be allowed to compound the weaknesses and inequities of the prospective pricing system for operating costs.

This AAMC statement on Medicare payments for hospital capital is organized into three sections. First, this statement reviews available data on the capital costs of teaching hospitals and concludes capital costs per unit of workload performed are higher in teaching than non-teaching hospitals. Second, this statement presents six principles for Medicare payment of capital costs which have been adopted by the AAMC's Executive Council. Third, this statement examines the Administration's proposal as the Association of American Medical Colleges understands it.

CAPITAL COSTS IN MAJOR TEACHING HOSPITALS

When Congress adopted the Medicare prospective payment system, capital costs of hospitals were excluded from the prospective payment and continued on a cost

reimbursement basis. The AAMC recognizes this exclusion does not reflect a Congressional commitment to continuing cost reimbursement for capital: it does reflect the presently inadequate, conflicting, and occassionally surprising information on capital costs of hospitals.

One of the initial surprises in the government's analysis of hospital capital costs in the Medicare program was the finding, by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), that capital costs in hospitals belonging to the Council of Teaching Hospitals (COTH) averaged 5.01% of total expenses while capital costs in non-COTH hospitals averaged 7.17%. Of equal significance was the ASPE finding that COTH members were consistently more heavily concentrated in the low capital cost categories, Table 1. Other ASPE analyses tended to corroborate the unexpected COTH/non-COTH differences in capital costs. As shown in Table 2, lower capital costs were also found in hospitals with CT scanners, pediatric/neonatal intensive care units, open heart surgery services, and Medicare case mix indices greater than 1.1.

Table 3 shows depreciation and interest expenses as a percentage of total hospital expenses for COTH and non-COTH hospitals for 1982. It should be noted that the interest expense percentage includes both interest paid on capital indebtedness and interest paid on working capital because the American Hospital Association's Annual Survey of Hospitals does not differentiate them. COTH members, as a group, report a lower percentage of expenses for both depreciation and depreciation plus interest. This is consistent with the ASPE findings.

In Table 4, depreciation and interest expenses for COTH and non-COTH hospitals are computed on a unit of workload basis using adjusted census days, adjusted patient days and adjusted admissions. Because depreciation and interest are reported on a hospital-wide basis, it is important to have a workload measure that represents both inpatient and outpatient services. The "adjusted data"

provides a comprehensive measure of hospital workload by increasing actual inpatient workload by a hospital specific factor designed to convert outpatient services into inpatient workload equivalents. In both depreciation and interest expenses categories, COTH hospitals report significantly higher expenses per workload unit. This finding of higher capital costs per unit of workload but lower costs as a percentage of expenses is also supported when depreciation expenses for COTH and non-COTH hospitals are compared by census region, Tables 5 and 6. Thus, major teaching hospitals have significantly higher capital costs per unit of workload than other hospitals.

In the past decade, construction and financing expenses have increased rapidly. As a result, hospitals having older facilities and equipment have depreciation expenses based on lower construction costs and financing costs based on lower interest rates. Table 7 shows the standard financial ratio "average age of plant" in COTH and non-COTH hospitals. The average age of COTH hospitals is 7.4 years while non-COTH hospitals average 6.7 years. COTH hospitals are 12% older, on average, than non-COTH hospitals. Average age of plant is shown by census region in Table 8. In seven of the nine regions, COTH hospitals have older plant and equipment than non-COTH hospitals.

The data analysis clarifies somewhat the capital costs of teaching hospitals. Without fully explaining capital costs, the data suggest two independent factors are acting to influence the relative capital costs of teaching hospitals.

First, major teaching hospitals do have greater absolute capital expenditures per unit of workload than other hospitals. At the same time, COTH members have relatively smaller capital costs when capital costs are compared to total hospital expenses, at least for periods in the early 1980's. This finding has significant implications in evaluating capital payment proposals from the

perspective of major teaching hospitals. Using historical data as an indictor of future relationships, the acceptability of a uniform capital "add-on" to the DRG payment system depends on major teaching hospitals receiving a percentage "add-on" computed using the total of basic DRG payments plus the resident-to-bed adjustment as the base against which the percentage is applied.

Second, the physical plant of COTH hospitals is, on average older than that of community hospitals. This implies that COTH hospitals are relatively under capitalized. If major teaching hospitals are to continue providing up-to-date technologies for diagnosis and care, major teaching hospitals are more likely to undertake major capital projects in the near term, a development which would raise their capital costs. This expectation is supported by Table 9 showing that COTH members, which have 18% of adjusted admissions, had 27% of the construction in progress in 1982. This suggests historical data, such as the 1981 Medicare data used by ASPE, may not accurately represent current capital expense patterns.

The current above average construction spending in COTH hospitals is further demonstrated in Table 10 where 1982 total construction expenditures for COTH and non-COTH hospitals are compared by census region and nationally. COTH members report higher 1982 construction expenditures per adjusted admission than non-COTH members. This expenditure pattern suggests that COTH hospitals view themselves as undercapitalized and are modernizing to alter this perception. As a result, relative capital costs in COTH hospitals can be expected to at least approximate those in non-COTH hospitals in the next few years.

In summary:

- historical data which compares capital costs to total expenses have been misinterpreted by some to imply that

major teaching hospitals have lower absolute capital costs than other hospitals

- o capital costs per unit of workload performed are higher in major teaching than other hospitals
- o Major teaching hospitals have older plants than other hospitals, and
- o recently increased capital spending by major teaching hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980.

AAMC PRINCIPLES ON CAPITAL PAYMENT

Analysis has shown that major teaching hospitals have greater capital costs per unit of workload than other hospitals. Given this observation and the "lumpy" capital cycle of major facility projects, the AAMC Executive Council has adopted the following six principles as recommended policy on Medicare payment for hospital capital costs

I. THE AAMC SUPPORTS REPLACING INSTITUTIONALLY SPECIFIC, COST BASED RETROSPECTIVE PAYMENTS FOR CAPITAL WITH PROSPECTIVELY SPECIFIED CAPITAL PAYMENTS.

Continuing the present open-ended cost passthrough for capital seems unlikely because it is philosophically inconsistent with prospective payment, is perceived to stimulate capital expansion and an over-investment in capital goods, and is likely to be under-funded or capped as service benefits for current beneficiaries are weighted against facility investments for future beneficiaries.

II. THE AAMC SUPPORTS SEPARATING CAPITAL COSTS INTO TWO COMPONENTS -- (1) MOVABLE EQUIPMENT AND (2) FIXED EQUIPMENT AND PLANT.

This separation, which has historically been maintained in accounting records, recognizes that expenditures for movable equipment are constantly made by hospitals and that the useful life of the items purchased is generally rather short. Expenditures for fixed equipment and plant, on the other hand, tend to aggregate into more infrequent major projects which have a relatively long useful life. Given these different characteristics, different apyments approaches may be used for movable equipment and for fixed equipment and plant.

III. THE AAMC SUPPORTS INCORPORATING CAPITAL PAYMENTS FOR MOVABLE EQUIPMENT INTO PROSPECTIVE PAYMENT USING A PERCENTAGE "ADD-ON" TO PER CASE PAYMENTS.

Because movable equipment purchases are a regular and ongoing component of hospital operations, no transition period or phase-in is required in order to include movable equipment in the pér case price. Incorporating movable equipmen into the prospective price would encourage managers to consider the relative advantages of capital and labor intensive alternatives. With both payroll costs and movable equipment incorporated into a single payment rate, a hospital would have the flexibility to select the labor-equipment mix most suitable to its particular circumstances.

IV. THE AAMC SUPPORTS A PERCENTAGE ADD-ON TO PER CASE PRICES FOR CAPITAL COSTS OF FIXED EQUIPMENT AND PLANT THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT PROVIDED THAT THE ADD-ON IS BASED UPON A PER CASE PRICE WHICH APPROPRIATELY

COMPENSATES TERTIARY CARE/TEACHING HOSPITALS FOR THEIR DISTINCTIVE COSTS.

In enacting the Medicare prospective payment system, Congress recognized that the operating costs of teaching hospitals are higher than those of non-teaching hospitals and included a resident-to-bed adjustment in the DRG payment to recognize this difference.

> This adjustment is provided in the light of doubts . . . about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents . . . The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

Thus, the patient care costs of teaching hospitals are met by combining the base DRG payment with the resident-to-bed adjustment. The AAMC believes capital payments made to teaching hospitals should be computed as a percentage add-on to the combined DRG and resident-to-bed payments.

V. THE AAMC SUPPORTS A LONG-TERM, HOSPITAL-SPECIFIC TRANSITION FROM THE CAPITAL PASSTHROUGH TO PROSPECTIVE PAYMENTS FOR PLANT AND FIXED EQUIPMENT.

In considering capital costs for plant and fixed equipment, it must be recognized that different hospitals are at various points in their capital cycles: some have new plants with high construction and financing costs; others have old plants and low costs but need to rebuild. Given this variability, the transition period should be long enough to recognize current obligations and make adjustments for plant additions approved by health planning agencies and alterations/modernizations required by life safety codes and licensing and accreditation agencies.

VI. THE AAMC SUPPORTS A TRANSITION PERIOD WHICH ALLOWS EACH HOSPITAL ITS CHOICE OF (1) COST REIMBURSEMENT FOR DEPRECIATION AND INTEREST ON ADJUSTED BASE PERIOD CAPITAL OR (2) A PROSPECTIVE PERCENTAGE ADD-ON THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT.

Under prospective payments, change is the order of the day. Hospitals are examining long-standing operational practices and altering those found inconsistent with the incentives and requirements imposed by the new payment system. While changes in daily operating practices may be difficult, the everyday nature of these activities provides numerous opportunities for changing practices. The construction and financing of major facilities offer less flexibility: planning the project and obtaining all necessary approvals is a multi-year effort, the asset itself has a long useful life, and the permanent financing often is for 15 to 30 years. As a result of these long term dimensions of major facility changes, the AAMC believes a change in capital payments must include adjustments honoring (1) the depreciation and interest originally anticipated for ongoing construction and recent plant additions; (2) new projects

in the final planning stages; and (3) expectations of bondholders, lenders and donors.

Under this transition policy, a hospital could elect to be paid on a cost reimbursement basis (depreciation and interest) for existing capital, capital projects under active construction, and capital projects for which a certificate of need was sought prior to a given date. These "base period" capital costs would be increased only for mandatory life safety or accreditation requirements approved by a planning agency. Capital payments would not be increased for facility modernizations, expansions, or replacements undertaken after the base period. At any time during the allowed period, a hospital receiving depreciation and interest payments could elect to change and receive the prospective capital add-on to DRG payments. Once a hospital elected the prospective add-on, it could not subsequently receive payments based on depreciation and interest.

The AAMC recognizes that hospitals with above average capital costs will probably select the depreciation and interest option initially while hospitals with below average capital costs will select the percentage add-on from the beginning. This pattern of choice, which increases Medicare expenditures from 1 to 2%, will help ensure the continued viability of hospitals with recent or ongoing construction projects and maintain access to the capital market for hospitals generally. The small increase in expenditures is a reasonable price to pay for converting hospitals from a capital system based on recovery of past expenditure to one based on capital formulation and the prudent investment of capital assets.

THE ADMINISTRATION PROPOSAL

The Administration's proposed budget for fiscal year 1987 advocates implementing a new policy for Medicare capital payments by regulation rather than legislation. The AAMC is strongly opposed to changing Medicare capital payments by regulation. A new capital policy necessarily involves balancing conflicting viewpoints and impacts. While the regulatory process includes an opportunity for public comment, the comments are often ignored and decisions on critical choices are made in closed meetings. The legislative process is preferred because it is more open and public. To ensure that the legislative process has an opportunity to consider a new capital payment policy;

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES STRONGLY RECOMMENDS THAT THIS SUBCOMMITTEE ADOPT LEGISLATION PROHIBITING THE SECRETARY OF HHS FROM MAKING CHANGES IN THE PRESENT CAPITAL PASSTHROUGH UNTIL CONGRESS ENACTS LEGISLATION DIRECTING THE SECRETARY TO IMPLEMENT A SPECIFIC CAPITAL PAYMENT METHODOLOGY.

Unless Congress takes this action soon, HHS has announced it will propose a new methodology on June 1 and publish it in final form on September 1.

Considering the specific features of the Administration's planned proposal, the AAMC has a number of concerns. First, if a percentage blend of hospital-specific and Federal components is to be used as the transition mechanism, the AAMC believes the phase-in should be across 10 years. The four year phase-in discussed by the Administration will have major adverse impacts on hospitals just completing or presently constructing major plant additions. Major teaching hospitals which would be harmed by this approach include:

The Presbyterian Hospital in the City of New York
The Mount Sinai Hospital, New York City
Temple University Hospital, Philadelphia
The University of Virginia Hospitals
The University of Michigan Hospitals
The University of Minnesota Hospitals and Clinics
St. Louis University Hospitals
Parkland Memorial Hospital, Dallas
University Hospital, Seattle
Stanford University Hospital,
and more.

Each of these tertiary care/teaching hospitals has just completed or is constructing a major facility which has required years to plan and approved by the certificate of need authority. In no sense have these hospitals "gamed the system" in anticipation of a future Medicare payment policy. Failure to recognize their increased capital costs could undermine the hospital's solvency and its ability to serve Medicare patients in the future.

Secondly, the AAMC is concerned that the Administration plans to use 1983 data for the Federal component. This base period does not include numerous capital projects which were underway before prospective payment began. The proposal compounds this shortcoming by using an update factor which reflects primarily the cost of borrowed capital, including working capital, and excludes the value of new capital. Use of this national index also precludes giving adequate consideration of regional differences in construction costs. To avoid these weaknesses,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE FEDERAL COMPONENT FOR COMPUTING CAPITAL PAYMENTS FOR A

PHASE-IN TRANSITION SHOULD BE BASED UPON ACTUAL 1986 MEDICARE CAPITAL PAYMENTS UPDATED ANNUALLY FOR INCREASED CONSTRUCTION AND BORROWING COSTS.

The Association is also concerned about the hospital-specific component t would be used for the percentage phase-in. By specifying that the hospital us the lesser of actual costs or adjusted base period costs, the Administration's proposal will penalize hospitals opening new projects. Many of the major plan replacements in major teaching hospitals are being built only after careful st and planning agency approval. Having behaved in a socially responsible way, t executives of the hospitals now find their hospital will be penalized financially. To ameliorate this inappropriate impact,

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THE HOSPITAL-SPECIFIC COMPONENT FOR COMPUTING CAPITAL FOR A PHASE-IN TRANSITION SHOULD BE BASED UPON EACH HOSPITAL'S ACTUAL CAPITAL COSTS FOR THAT CURRENT YEAR

CONCLUSION

Developing a new approach to paying for capital involves trying to solve difficult problems simultaneously. First, hospitals must transition from a period of retrospective recovery of capital costs to a new era of a priori capital development formation. This takes time. Secondly, hospitals are at differing points in a very "lumpy" capital cycle which is characterized by hi costs when facilities are new and by low costs when facilities are old. This requires attention to hospitals at both ends of the cycle. To develop a new capital policy which preserves the financial viability of hospitals while treating them equitably will be most difficult.

If the Medicare system for paying hospitals for capital costs is to be changed, the AAMC believes great care should be taken before the change is made. The DRG system for paying operating costs was preceded by several years of research and a number of demonstration projects. No similar effort has been made for capital payments. In fact, the AAMC has yet to see the DHHS study on capital costs which is now overdue by more than a year. When that study and the Administration's recommendations are presented, the AAMC would welcome the opportunity to testify once again on Medicare payments for hospital capital.

Table 1

Percentage Distribution of Capital Costs as a Percentage of Total Expenses by Membership in the Council of Teaching Hospitals, FY 1981

Percentage of Capital Costs	Percentage of Hospitals	
	COTH	Non-COTH
Less than 4%	37%	25%
4% to 6.57%	39	34
6.58% to 9.99%	17	23
10.0% to 14.99%	6	13
15% to 19.99%	1	4
20% or more	1	2
TOTAL	101%	101%

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 2

Capital Costs as a Percentage of Total Costs
by Selected Hospital Characteristics, FY 1981

Hospital Characteristic	Number of Hospitals	Mean Percentage of Expenses for Capital Costs
CT Scanner		
Yes	1108	6.47%
No	3867	6.75
Pediatric/Neonatal ICU		
Yes	1215	6.09
No	3760	7.09
Open Heart Surgery		
Yes	463	6.09
No	4512	6.85
Medicare Case Mix Index		
Less than .9	862	5.64
0.9 - 1.0	1517	6.72
1.0 - 1.1	1631	7.16
More than 1.1	814	6.07

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

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Table 3

Depreciation and Interest as a Percentage of Total Expenses for COTH and Non-COTH Hospitals, 1982

Expense Type	Percent of Total Expenses: COTH Members	Percent of Total Expenses: Non-COTH
Depreciation	3.7%	4.2%
Interest	2.7	2.7
Depreciation and Interest	6.4	6.9

Source: AHA Annual Survey, 1982 data.

Table 4

Depreciation and Interest Expenses per Adjusted Census Day, Adjusted Patient Day, and Adjusted Admission in COTH and Non-COTH Hospitals, 1982

Workload Unit	Expenses per Workload Unit: Depreciation: COTH	Depreciation: Non-COTH	Interest: COTH	Interest: Non-COTH
Per Adjusted Census Day*	$8,596	$4,003	$4,345	$2,902
Per Adjusted Patient Day	23.50	10.90	11.91	7.95
Per Adjusted Admission	203.90	80.90	103.09	58.69

Source: AHA Annual Survey, 1982 data.

* A census day is equal to one bed occupied for 365 days. It is computed by dividing total patient days by 365.

Table 5

1982 Depreciation Expenses as a Percentage of
Total Expenditures in Short-Stay, Non-Federal Hospitals
by Membership in COTH and Census Region

Region	Depreciation as a Percentage of Total Expenses	
	COTH	Non-COTH
New England	3.5%	3.6%
Middle Atlantic	3.7	3.9
South Atlantic	3.8	4.3
East North Central	4.3	4.4
East South Central	4.3	4.4
West North Central	2.7	4.6
West South Central	3.9	4.3
Mountain	4.3	4.2
Pacific	2.9	3.9
National	3.7%	4.2%

Source: AHA Hospital Survey, 1982 data.

Table 6

Depreciation Expenses per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	1982 Depreciation Expense Per Adjusted Admission	
	COTH	Non-COTH
New England	$135.22	$ 86.94
Middle Atlantic	137.24	91.90
South Atlantic	133.45	88.02
East North Central	166.44	103.42
East South Central	128.87	77.13
West North Central	130.12	99.77
West South Central	122.68	81.93
Mountain	133.11	91.89
Pacific	128.57	111.08
National	$140.23	$ 92.93

Source: AHA Hospital Survey, 1982 data.

Table 7

Average Age of Plant in Short-Stay,Non-Federal Hospitals by Membership in COTH, 1982

Type of Hospital	Average Age of Plant*
COTH Hospitals	7.4 years
Non-COTH Hospitals	6.7 years

$$\text{*Average Age of Plant} = \frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$$

Source: AHA Hospital Survey

Table 8

Average Plant Age in Short Stay
Non-Federal Hospitals by
by Membership in COTH And Census
Region, 1982

Region	Average Age of Plant* COTH Hospitals	Average Age of Plant* Non-COTH Hospitals
New England	8.74	8.16
Middle Atlantic	8.00	7.53
South Atlantic	7.04	6.19
East North Central	6.81	7.17
East South Central	7.32	6.22
West North Central	7.51	7.21
West South Central	6.74	6.01
Mountain	5.80	6.05
Pacific	7.74	5.99

*Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Annual Hospital Survey

Table 9

1982 Construction in Progress in Short-Stay, Non-Federal Hospitals by Membership in COTH

Type of Hospital	Percentage of Admissions	Construction in Progress	
		Amount	Percent of Total
COTH Member	18%	$1,603,593,494	27%
Non-COTH	82%	2,818,714,864	73%
Total		$4,422,308,358	100%

Source: AHA Hospital Survey

Table 10

1982 Construction Expenditures per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	82 Capital Expenditures Per Adjusted Admission	
	COTH	Non-COTH
New England	$307.44	$170.71
Middle Atlantic	368.39	274.83
South Atlantic	349.91	258.55
East North Central	505.27	255.66
East South Central	649.29	247.71
West North Central	637.46	237.17
West South Central	351.64	230.73
Mountain	520.81	248.97
Pacific	366.07	278.86
National	$421.50	$254.50

Source: AHA Hospital Survey, 1982 data.

Statement of the
Blue Cross And Blue Shield Association

The Blue Cross and Blue Shield Association is pleased to present comments for the record on Medicare hospital capital payment reform. The Association is the national coordinating agency for all of the nation's Blue Cross and Blue Shield Plans.

The deliberation of the Subcommittee on reform of Medicare capital payment policy can have a direct impact for years to come on the hospital industry's ability and capacity to serve not only the Medicare population, but all the people of this country. The Medicare program is such a major source of revenue to hospitals (about 40% on average for inpatient services) that any significant change in payment policy must be considered carefully.

Need for Reform

When the Congress enacted the Medicare prospective payment system it exempted hospital capital-related costs — depreciation, interest, and return on equity capital payments — from the new system and set October 1, 1986 as the deadline for adopting a new capital payment policy. As a result, capital costs continue to be paid on a cost reimbursement "pass-through" basis. In 1983, the Congress also gave notice that capital obligations entered into by hospitals after March 1, 1983 may receive different treatment under the new capital payment policy than earlier obligations.

Hospital investment in capital is a significant and essential element in producing quality health care. Periodic reinvestment is necessary to maintain, renovate and replace facilities, as well as to modify services. It is often necessary to invest in order to improve the efficient operation of a facility. The challenge to payors of health care is to recognize this in payment systems without encouraging or contributing to capacity or services that are not needed and without undermining the capacity to provide needed services.

With respect to the Medicare program, the current mix of prospective payment for operating costs and cost reimbursement for capital expenses creates a number of problems. Most importantly, it creates inappropriate incentives for hospitals to substitute capital for labor or other inputs. If both types of expenses were covered under a prospective

payment system, hospital resource allocation decisions regarding plant, equipment, staffing and support functions would be based primarily on the need to improve efficiency and maintain or improve patient care.

In addition, cost reimbursement for hospital capital expenses, without effective limitations, does not promote financial discipline because it insulates hospitals from the negative consequences of poor investment decisions. The current method of determining Medicare cost reimbursement for capital expenses "subsidizes" excess hospital capacity. For example,if a 200 bed hospital is operating at only 50% of full capacity and Medicare patients represent 50% of the total patient load, the Medicare program could pay half of the hospital's capital expenses relating to maintaining its full 200 bed capacity.

These problems have led to proposals by the Administration and Members of Congress to include a factor for capital costs in Medicare prospective payment rates for hospitals.

Principles of Reform

We agree in principle with the development of capital--inclusive DRG pricing. In our view, the advantages of incorporating capital costs as part of the overall DRG price far outweigh the disadvantages. It is consistent with the price-based payment method created under PPS and links payment for capital directly to actual patient volume rather than to the hospital's total capacity which may be excessive. It also eliminates the artificial separation of capital and operating costs reimbursement, thereby promoting more rational decisionmaking by hospitals concerning the allocation of its resources. Finally it creates incentives for hospitals to evaluate carefully proposed capital expenditures and defer projects when the cost of capital is high.

In our view, there are four principles that should guide the development and evaluation of specific reform proposals. They are providing 1) a reasonable transition, 2) an adequate basis for determining average payment levels, 3) an adjustment process for exceptional circumstances, and 4) establishing reform through the legislative process.

First, we believe that a reasonable transition provision should be provided to enable hospitals time to adjust to the new method. Developing transition policy involves

consideration of the length of the transition, the rate at which the new capital payment system is phased in, and the basis for calculating payment amounts.

A reasonable transition period is essential to the financial stability of hospitals that are highly leveraged with respect to capital expense at the time the transition period begins. Such hospitals individually could abruptly lose millions of dollars in otherwise anticipated Medicare payments. The transition period provides hospitals the opportunity to adjust operating and financial plans to assure a balance between revenues and expenses. This is essential if hospitals are to be able to meet the expenses of already incurred fixed capital expenditures.

On the other hand, those hospitals that have capital expenses below the national average, including many public hospitals, will benefit from a shift to DRG-based capital payments. While this may be viewed as a positive consequence of the proposed policy, we do not believe the additional infusion of dollars should be at windfall levels. A longer transition period still infuses additional Medicare revenues into those hospitals, but at a more moderate pace than does a short transition.

The rate at which the new payment system is phased in is also an important consideration. To assure a smooth transition, we believe that the hospital-specific portion of the rate should be heavily weighted in the earlier years of the transition. To make this portion of the rate truly hospital-specific, we believe that the hospital's actual capital costs during each year of the transition should be used as the basis for determining the payment rate. This could be accomplished by estimating for the hospital-specific portion of the payment each hospital's capital costs at the beginning of the rate year and then adjusting that amount after receipt of the Medicare cost report.

The second recommended principle of reform relates to the national average level at which prospective payments for hospital capital will be set. We believe that Medicare payments for capital should be adequate to recognize the costs that hospitals must incur in providing needed services to beneficiaries and should reasonably reflect overall trends in market conditions. We caution against viewing revising payment to hospitals for capital primarily as an opportunity to achieve budget savings. The basic design of the system could reduce aggregate Medicare payments for capital absent a requirement for

budget neutrality. Changes in Medicare's payment policies for hospitals' capital expenditures carry far-reaching implications for the cost and availability of health care services in the United States. Therefore we urge careful consideration before proceeding with further reductions to the cost base used to establish national average payment levels.

Third, because a national Medicare payment system cannot be as sensitive to unique and local circumstances as may be appropriate, we believe a mechanism should be established to authorize adjustments to capital payments where this is clearly demonstrated to be necessary for the continued viability of needed facilities. Related to this is the need to establish a data gathering and monitoring system that can track the effects of the new payment system on the hospital industry including its effect on capital formation. Adjustments to the DRG weights or to the average payment levels to reflect new technology, availability of financing, and the aging of facilities are among the important capital-related issues that need to be monitored and addressed in the future. This can be done only with a serious commitment to the monitoring and evaluation process.

Fourth, we believe as a matter of principle that revising Medicare payment policies for capital should be the subject of broad public debate and should be considered as part of the legislative process rather than as a regulatory matter. The legislative process would in our view provide ample opportunity for public input and a more reasonable time period to assess the potential effects of various reform proposals on the nation's hospitals.

The Administration's Proposal

Under the Administration's proposal, a set amount for capital would be added on to PPS rates. According to recent Congressional testimony by the Department of Health & Human Services, the amount for capital would be a blend between the national average amount per DRG and a hospital-based component based on historical costs updated by a trend factor. Over a four-year transition period, the capital add-on increasingly would be based more on the national average and less on the hospital-specific factor. We question whether the Administration's proposed payment method will, in practice, fairly compensate health care institutions' capital costs. Critical in this regard are

the formula used to calculate the average payment amounts and the length of time and manner of transition for implementation of the new capital payment method.

It is important to understand that shifting to a per case payment unit for capital redistributes the pool of Medicare dollars differently across hospitals than does the cost reimbursement formula. The length and blending proportions of the transition should be designed to assure that this redistribution occurs gradually. The Administration's proposal could jeopardize many hospitals' financial security by placing too little emphasis on hospital-specific costs during the transition and by providing too little time to allow hospitals to adjust to the new payment system.

For example, the hospital-based payments would not be truly hospital-specific since the Administration plans to use a fixed base of FY 1983 capital payments to determine each facility's hospital-based payment. Also, the hospital-based amount declines very rapidly as a proportion of the total capital payment over the four year transition. Another example of a too abrupt transition relates to the way in which return on equity and interest on funded depreciation are treated for purposes of the hospital-based payments. Payment for these elements would be phased out of the hospital-based portion of the rate over a three year, rather than a four year period. While we agree that payment for return on equity and interest offset need not be continued under the prospective payment system, we question whether payments for these factors should be reduced as abruptly as the Administration proposes.

Conclusion

We are pleased that the Congress and the Administration are devoting considerable efforts this year to the reform of Medicare capital payment policies. The failure to agree on a specific proposal this year will only postpone the introduction of needed reform, and will further increase the uncertainty under which hospitals must make investment decisions that are critical to the future of the health care delivery system. We fully support the principle of incorporating a capital element into Medicare prospective payment rates and look forward to assisting the Subcommittee in any way we can as you proceed in this very important but highly complex area.

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Fitch Investors Service is one of three national rating agencies. Its Health Care Division has been rating publically offerred taxable and tax-exempt debt issues for the health care industry since 1955. Fitch has been retained to rate or otherwise evaluate debt issues for approximately one out of three qualifying hospitals in the United States.

OUTLINE OF STATEMENT

1. Capital Costs are fixed costs and should not be shifted to other user (or payer) groups.
   a. A shift will cause higher premiums and less hospital usage.
   b. Less hospital usage is not the goal of PPS.

2. Fitch wishes to establish two separate payment mechanisms:
   a. Capital costs incurred before 10/86 to be reimbursed under a reasonable cost basis.
   b. After 10/86, specific reimbursement ought to be established.

3. The committee should be aware of other factors which are causing shrinkage in the accumulation of capital. These factors indicate a lessing of capital needs for new projects, and, by implication, of the amount of Medicare reimbursement therefore.

This statement is given in response to the current HHS plan to incorporate capital cost payments into the DRG Prospective Payment System (PPS) over the next four years. We are opposed to the HHS plan and wish to set forth an alternative method for the payment of capital cost items by the Medicare Program.

The current DRG system (without capital cost items included) has achieved its desired primary goal, namely, to enable the hospital to become cost efficient in its delivery of care. However, we believe that the reason why the hospital has become cost efficient is because it is dealing with a mixture of variable and semi-variable costs which, by definition, are arbitary and therefore to be manipulated, shifted, reduced, or otherwise changed in order for the hospital to equal or exceed PPS. In other words, cost recovery and perhaps incremental profits through the present PPS system could be achieved by: (1) micro costing techniques designed to isolate and therefore cause reduction in direct and indirect costs; (2) reduced Average Length of Stay; (3) other means, such as physician and nursing staff education. Our current survey of the present DRG experience indicates a reasonable to very strong success with PPS by perhaps as much as 95% of our rated hospital issuers. We therefore conclude that the present system is working well and that most hospitals are not at risk.

However, the introduction of the proposed capital cost "fold in" to PPS as a non-labor portion would indeed cause a serious risk factor to many hospitals because they can not comfortably absorb these fixed costs and therefore must shift such expenses to other patient payer categories in order to make up the difference for shortfalls between actual capital expense and PPS. The inevitable result will be that the patient with commerical insurance, including Blue Cross, will end up paying the difference. As the cost of coverage escalates, the patient with commercial insurance (which accounts for roughly 55 to 60 percent of all hospital revenues) will seek alternative health delivery systems, thus causing a more intensive shakeout and, in part, ensuring the demise of as many as 500 hospitals as soon as 1990.

The U. S. Government ought to stand by its implied obligation to pay a reasonable cost based reimbursement given to all hospitals who incurred capital related expense <u>prior to</u> October 1986. We therefore believe that all associated capital expense for programs incurred prior to October 1986 should be a pass through and should be reimbursed on a reasonable cost basis. We further believe that all costs incurred <u>after</u> October 1986 should be paid on an adjusted (total) program cost basis approach within the following parameters:

1. Capital costs to be reimbursed under Medicare must be associated only with those projects which directly benefit the Medicare patient.
2. The same criteria must be developed for all major equipment purchases over a specified dollar amount.
3. The cost of capital for new projects should be tied to the Treasury Bill or similar rates and a uniform interest reimbursement rate should be implemented.
4. A regulatory agency should be established to ascertain that this payment criteria is enforced at all times.

The establishment and maintenance of such criteria will ensure that all qualifying providers can equally access the capital market for their future projects which are Medicare related. We believe that this methodology would cause substantial and immediate savings to incur.

This Rating Agency believes that it is prudent on the part of both proprietary and non-for-profit providers to maintain sizeable liquid assets, especially cash and equivalent items which are earmarked toward the replacement of plant and equipment (i.e. Funded Depreciation). We generally award a higher rating designation when we see that the provider to be rated maintains Funded Depreciation on a consistent basis. The higher the rating, the greater the interest savings. Thus differences in a rating letter grade and especially between the "A" and the "BBB" could be as high as 1% (100 Basis Points) or more and could result in substantial savings over the term of the issue. The no interest offset is an incentive for hospitals to maintain Funded Depreciation and should not be eliminated. Return on Equity to investor owned hospitals should also be kept because it ensures the continuation of the proprietary provider operation--a viable and growing segment of the hospital delivery system.

Several factors are now operating to bring down future hospital capital costs. There is now a drastic reduction in tax-exempt bond volume because of proposed tax reform measures. For example, in 1985, the tax-exempt hospital bond market (which accounts for more than 80% of all hospital financings) achieved a volume of financings of $27.9 billion (up considerably over the $10.1 billion occurring in 1984). We would be optimistic to expect 7 billion to occur in 1986. More likely, it would be 4 to 5 billion. This decrease may, in fact, be a permanent situation and, if it continues, should cause a sizeable savings in capital related Medicare reimbursement to occur. Alternative delivery systems, particularly HMO's, should help to depress hospital capital spending for the next decade and beyond. Both of these factors should greatly influence future decisions by providers to access the capital markets.

In summary, the basis of our opposition of the proposed inclusion of capital costs into a DRG rate is the fact that those fixed costs incurred for past projects receiving state and federal approval ought to continue to receive Medicare's proportionate share in reimbursement. Neither should those costs be shifted to the private sector. In the future, all projects should relate to the treatment of the Medicare patient in order to be reimbursed. The No Interest Offset and Return on Equity should be treated as benefits to the provider which ensure their continued participation in the hospital delivery system and should not be excluded. Finally, the inclusion of capital costs into PPS will be deemed to be a risk factor to the Rating Agency and may cause a reduction in current or future ratings, thus increasing the cost of capital for hospital projects.

Respectfully submitted,

FITCH INVESTORS SERVICE, INC.

Paul X. Savageau

Paul X. Savageau
Senior Analyst

STATEMENT

of the

HERMANN HOSPITAL

HOUSTON, TEXAS

by

Jeptha W. Dalston, Ph.D.

Chief Executive Officer

Hermann Hospital

PROPOSAL TO INCORPORATE CAPITAL COSTS INTO MEDICARE'S PPS

These comments on the Administration's proposal to incorporate capital costs into prospective payment system are submitted on behalf of Hermann Hospital.

Hermann Hospital was the first hospital in, and the cornerstone of, the Texas Medical Center, Houston's major medical complex. The hospital was established in 1925, and today is licensed for 908 beds.

It is accredited by the Joint Commission on the Accreditation of Hospitals, and employs some 3,000 health care and support personnel. The majority of the hospital's patients are from Houston and southeast Texas, but a large number of patients are from other states and foreign countries.

Since 1968, Hermann Hospital has been affiliated with, and is the primary teaching facility for, The University of Texas Medical School at Houston. As a teaching hospital, Hermann provides all five categories of medicine - surgery, internal medicine, pediatrics, obstetrics and gynecology, and psychiatry - as well as all subspecialties.

Hermann is one of the few major teaching hospitals in the U.S. that is private, non-profit, non-sectarian, and receives no tax support.

The following comments detail the potential effects of the Administration's proposed regulations on our institution.

roposed Regulations

The primary uncertainty in the Administration's proposal for capital reimbursement is what the national rate will actually be. If proposed figures have been published, they have not come through this office. One proposal was that a capital add-on be determined for each DRG, reflecting the capital equipment required for treating that illness. Other proposals suggest a percentage add-on. Several years back the figure of a 7 percent add-on was discussed, with 7 percent having been the national average of depreciation and interest expense relative to total expense. Another proposal was to add a flat dollar amount to each DRG, updating that amount yearly. The association of American Medical Colleges recommends using $282.57 per discharge for 1987 as a flat add-on per case. Both this and the 7 percent add-on were analyzed in this analysis.

The administration's proposal phases in the national rate over five years. The Hospital portion is to be the lower of 1986's capital costs or the actual capital costs incurred in the year. Given Hermann's level of renovation the assumption was made that 1986's costs would be used.

Financial Impact on Hermann Hospital

The financial impact of either national rate structure is definitely negative to Hermann. Compounding the problem is the realization that future capital expenses will not increase the Medicare capital reimbursement at all. Planning for future capital expenditures should be made with this in mind.

Table I shows the anticipated decrease in capital payments under the administration proposal. The difference between the national rate, set at a 7 percent add-on, and current reimbursement is approximately $1,000,000 per year after phase-in. The difference between the national rate, set at a fixed dollar add-on, and the current rate is $1,500,000

after phase-in. The losses under the 7 percent add-on are surprising since Hermann's ratio of depreciation and interest expense relative to total expense is only 6.34 percent in 1985, 6.94 percent in 1984. The shortfall comes about for two reasons. First, Medicare costs as determined by the cost report constitute a higher percentage of total costs than either the percentage of Medicare days to total days or Medicare revenue to total revenue. The result is that Medicare is paying a higher percentage of the total capital than they otherwise might. Second, the 7 percent is of DRG reimbursement, not revenue or expense.

The second alternative, the fixed dollar add-on is even worse for Hermann. The reason for this is that it is a per discharge add-on, and does not reflect case mix, as DRG payments do. Because Hermann's case mix uses approximately 25 more resources than the national average, this reimbursement scenario falls short of realistic capital payment.

EXPENSES ON PROJECTS (CIP)

	SEPT 1982	SEPT 1983	SEPT 1984	SEPT 1985	SEPT 1986	TOTAL
A. CONSTRUCTION IN PROGRESS:						
ADDITIONS	465,823	482,663	232,859	3,234,197	2,753,495	7,169,035
B. HE PROJECTS TRANSFERRED TO HERMANN HOSPITAL:						
HH LANDSCAPING	1,458,237					1,458,237
FLOOD PROOFING	682,540					682,540
PSYCHIATRIC DINING	231,688					231,688
CT SCANNER	214,790					214,790
CARDIAC CAT LAB	1,761,988					1,761,988
PHASE III	11,060,359	9,918				11,070,277
CHAPEL FLOOD	166,935					166,935
8th & 9th FLOOR	10,567,667	105,310	219,151			10,892,128
BURN UNIT		591,447	5,101			596,548
CLINICAL LAB		3,899,391				3,899,391
BLOOD BANK			13,654			13,654
CHILDREN TERRACE			200,146			200,146
CULLEN INTERNAL MED.			122,908			122,908
ROBERTSON PAV. RENOV.			25,425			25,425
CCU/POSITRON			1,965,750			1,965,750
JONES RENOV.			877,514			877,514
OB RENOVATION			318,824			318,824
CLINIC RELOCATION			32,925			32,925
AUDIOLOGY			341,149			341,149
TOTAL	26,610,027	5,088,729	4,355,404	3,234,197	2,753,495	42,041,852

pages tightly bound

STATEMENT OF THE
HOSPITAL ASSOCIATION OF NEW YORK STATE

ON
A NEW MEDICARE REIMBURSEMENT MECHANISM FOR CAPITAL COSTS

PREPARED FOR A
PUBLIC HEARING HELD BY

HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

Washington, D.C.
February 24, 1986

74 N. Pearl Street, Albany, N.Y. 12207 518/434-7600

Summary of Key Points

Before Congress considers a specific proposal for the incorporation of capital payments into the Medicare Prospective Payment System (PPS), we urge the immediate adoption of an explicit statutory prohibition on the Department of Health and Human Services (HHS) from incorporating capital into PPS by regulation.

We further urge that Congress delay for one year - until October 1, 1987 - the prospective date of incorporation of capital into PPS to allow for an environment more conducive to consideration of the serious public policy implications surrounding this issue.

Any proposal to incorporate Medicare payments for hospital capital expenditures into the prospective payment system (PPS) must include the following basic principles:

1) While there may be a great temptation to cut the federal budget deficit by reducing Medicare capital payments, any new methodology must not be used as a vehicle to achieve budget savings.

2) There must be a reasonable transition. The transition to a federal rate for building and fixed equipment must be at least 12 years, and the transition for movable equipment must be at least 5 years.

3) The federal portion of the capital rate must be based on data for the most recent 12 month period prior to the effective date of the new methodology.

4) The hospital specific portion of the capital rate must be based upon each years actual expenditures.

5) The capital rate must recognize the additional cost of graduate medical education, as well as the additional costs to hospitals that serve the medically indigent.

6) A new capital cost methodology must be coupled with a repeal of section 1122, and a federal pre-emption of state assessment of Medicare revenues for the purposes of creating a state operated capital funding pool.

7) A new methodology must provide for exceptions and exemptions especially for inner-city and rural hospitals. In addition, it must make special provision for facilities that recently undertook capital projects.

8) A new methodology must recognize the distinction between old capital and new capital. Old capital must be defined as capital already expended or for projects under construction prior to the effective date of the new methodology.

9) A new methodology must recognize regional differences in construction costs.

In addition to these basic principles, which must be incorporated into Medicare statute, there are other basic standards which must guide the development of a new payment methodology for hospital capital costs. Primary among these is the basic principle that any changes in capital reimbursement policy must be made by Congress rather than by the Administration through regulation.

Finally, any federal policy regarding Medicare treatment of capital expenditures must be a part of - and cannot be divorced from - a broader federal policy regarding hospital access to capital. As such, that broader federal capital policy must also include the preservation of voluntary, not-for-profit hospital access to tax-exempt bond financing as well as the continuation of federal loan guarantees under section 242 of the FHA Mortgage Insurance Program.

As the attached table shows there is a tremendous variation in the ratio of capital operating costs in New York State. Those with high ratios - from 12% to 45% - would obviously be imperiled by a normative dollar amount or percentage add on to the PPS prices. Not so obvious are the serious consequences for those hospitals with low capital to operating cost ratios. Those institutions, by definition, have capital assets that are nearly fully depreciated and obsolete. They are not competitive and will suffer declines in volume, and therefore further reductions in capital payments.

Obviously this is not a simple problem that can be addressed with overly simplistic solutions.

This statement is prepared on behalf of the 229 public and voluntary, not-for-profit hospital members of the Hospital Association of New York State (HANYS).

Statement of the Issue

When Congress enacted the Medicare Prospective Payment System (PPS) in 1983, it exlcuded payments for certain hospital expenditures from incorporation into the new payment system. Expenditures for direct graduate medical education costs would be paid on the basis of a reasonable cost pass-through since not all hospitals were involved in medical education programs and to incorporate such costs into PPS would be a distortion of the payment mechanism. At the same time, payment for capital costs were also excluded from PPS - to continue on a reasonable cost pass-through basis - at least until October 1, 1986. Section 1886(a)(4) of the Social Security Act - as added by P.L.98-21 - specifically excludes from the definition of operating costs for hospital inpatient services capital costs "incurred in cost reporting periods beginning prior to October 1, 1986."

At that time, it was the intent of Congress, as expressed in the Conference Report (House Conference Report No.98-47) that capital would be incorporated into PPS by legislation prior to October 1, 1986. The legislation, however, did not preclude the Secretary of Health and Human Services (HHS) from incorporating capital into PPS by regulation

effective October 1, 1986. In addition, the legislation also required the Secretary to submit a report to Congress, by October 1984, containing "a thorough review of the methods by which capital, including return on equity, can be incorporated into the prospective payment system." To date, that report has not been submitted.

Current Status

In the absence of the Congressionally mandated report, the Department of Health and Human Services, as part of the Administration's Fiscal Year (FY) 1987 budget, has outlined a proposal for the incorporation of capital into the Medicare Prospective Payment System (PPS) by regulation. In all likelihood, this proposal will be included in the overall PPS regulations to be published in the Federal Register by June 2, 1986. The HHS proposal is clearly budget driven - it seeks a $456 million reduction in Medicare capital outlays in FY 1987 and $11.1 billion over a five year period. In essence, the HHS proposal would base capital payments on a blend of 1983 national Medicare capital expenditures and the lesser of 1986 hospital-specific capital or current year capital expenditures. Eliminated from 1983 national base year expenditures are several important elements, including return on equity, interest on funded depreciation accounts, and donated assets. Over a four-year transition period the hospital-specific portion of capital incorporated into PPS would be eliminated so that by FY 1991 the capital payment level would solely reflect average national payments per discharge.

The Hospital Association of New York State is strongly opposed to he HHS proposal as being violative of Congressional intent and the asic principles of fairness and equity which we shall outline further n in this statement. In addition, we must oppose any proposal which s solely budget driven and not based upon the development of a sound nd rational policy designed to meet the capital needs of the hospital ector.

Additional proposals for the incorporation of capital into PPS nclude one by Senator David Durenburger (S.2121), which differs rimarily from the HHS proposal in the length of the transition period 7 years) to a national payment amount, and one by the Congressionally stablished Prospective Payment Assesment Commission (PROPAC).

The PROPAC recommendations include distinctions between building nd fixed, and movable equipment, retains return on equity and interest n funded depreciation accounts within the federal portion of payment ates, includes the possibility of a regional adjustment factor and ould also provide for a longer transition period than the HHS propo- al. While our Association is not prepared to endorse the PROPAC ecommendations as currently put forward, we believe their proposal ontains several provisions worthy of serious consideration by Congress n the development of a capital payment policy for Medicare.

Immediate Decisions that Must be Made by Congress

It is the strong belief of our Association that only Congress has the ability to develop a fair and equitable policy for the incorporation of capital into Medicare PPS. This belief is especially strengthened by the recent manipulation of PPS by HHS through the regulatory process in violation of Congressional intent to implement a fair, equitable and predictable payment mechanism for hospital services to Medicare beneficiaries, as well as HHS' continual failure to submit Congressionally mandated reports on PPS, and to implement Congressionally mandated refinements and adjustments in the payment mechanism.

Congress must maintain its appropriate role in the development of Medicare policy, we therefore urge the immediate adoption of an explicit statutory prohibition on HHS from incorporating capital into PPS through regulations planned to be published by June 2, 1986. This is an essential first step in the process of Congressional development of a Medicare capital payment plan for hospitals.

Should Capital be Incorporated Into PPS, and If So, When?

The issue of whether Medicare payments for capital should be incorporated into PPS is still a valid one for serious national debate. While Congressional intent, as expressed in the 1983 PPS legislation, was that such was to be accomplished by October 1, 1986, that intent was also premised on the assumption that a Congressionally mandated

report on the issue from HHS would be submitted by October 1984. That report - which could have served as the focus for the development of Congressional capital payment policy - has, as previously indicated, not been submitted. In its absence, we are confronted with a budget driven proposal from HHS and several competing proposals.

On the broad questions of whether capital payments should be incorporated into PPS, there are several strong arguments on both sides of the issue. It can be argued that the incorporation of capital into PPS is consistent with the goals of administrative simplicity, flexibility for hospital management, predictability of payment, and incentives for efficiency - all goals of PPS generally. We question, however, whether these goals have been achieved for PPS based on HHS' manipulation of Congressional policy intent through regulation, as well as its failure to comply with several clear Congressional mandates.

On the other side, it can be argued that the treatment of capital separate from PPS is the most equitable method of dealing with such expenditures. The separate treatment of capital is able to address hospital specific needs especially as it relates to variations in capital commitments, regional differences in capital construction costs, the age and useful life span of physical plants, and the need to maintain a viable hospital infrastructure. In addition, such a system also avoids the oversimplification of the broad policy issues inherent through development of a national average payment approach.

It is not our intent to engage debate on this issue in this statement. But to only raise the broad policy questions which need to receive more thorough discussion and debate.

As such, our Association strongly urges Congress to delay for one year - until October 1, 1987 - the effective date of Medicare's incorporation of capital payments into PPS. We believe that such a delay would provide further time to adequately address the policy issues involved, as well as to focus discussion in an atmosphere conducive to the development of fair and equitable policy, and not one driven solely by budgetary considerations.

Historical Development of the Hospital System, and the Influence of Government

Before discussing the specific basic principles which must be included in Medicare capital payment policy changes, it is important that the discussion be framed in an appropriate historical context - one which focuses on the development of the hospital system, the influences of government and the directions - or lack of - federal health policy.

The belief, as incorporated into PPS, that hospitals should receive a single price for their services would appear to be based on the notion that hospitals are primarily businesses and secondarily providers of health care services. Indeed, when the current Administration first came into office, they believed that "free-market

competition" would solve the ills of our economy - a philosophy, which to varying degrees, has been transferred to the health care sector as well. Unfortunately, life is not that simple and the notion that competition is going to solve all of the problems of our social and health care system is naive. The debate about the future of the hospital sector, and the health care system in general, reflects the national schizophrenia about the role of the hospital in society. We are not sure whether we want our hospitals to be charitable institutions, public utilities, or money-making enterprises.

By tradition, hospitals were charitable institutions. They took care of the poor, the elderly, travelers, pilgrims, soldiers, and, when necessary, the ill and infirm. Most of the older hospitals in this country started as institutions for the poor who had nowhere else to go. In 1751, Benjamin Franklin composed the cornerstone for the then new Pennsylvania Hospital. He wrote, "This building, by the bounty of the government and many private persons, was piously founded for the relief of the sick and miserable."

During the depression of the 1930s, there was a growing belief that government had an obligation to make public services and utilities available to everyone. Government programs created public water supplies, electric projects, and public transportation systems. After the Second World War, we began to think of hospitals as public utilities. Congress enacted grant programs and programs offering low interest loans for hospital construction. Government programs like the Hill-Burton program financed hospital construction throughout the

country. We also changed the way we paid for care. Employee health benefits became a demand of almost every union. The biggest change, however, came from the enactment of Medicare and Medicaid in 1965. Government told hospitals, "Take care of our patients, treat them exactly like you treat your private customers, let them have semi-private rooms and we will pay the cost of that care - including capital costs."

Cost - not price. The theory behind public utilities proclaims that public utilities are essential to the public's well-being; as such they must be protected from the uncertainties of the free market. The free market means uncertain prices, the laws of supply and demand, the possibility of going bankrupt, and the loss of services to the public. When hospitals started getting paid based on what it cost them to produce services, they started acting like other public utilities. They met consumer demands for new and better services, assumed debt, and undertook large capital projects. In many states, hospitals found that they could make money, and the development of the large for-profit hospital chains soon followed.

Up to that point, most hospitals were either charitable institutions or community providers. The purpose of the proprietary hospital corporations was and is to make a profit. The annual report of the Hospital Corporation of America stated its purpose, "To provide a reasonable and fair return to stockholders while minimizing risk." The annual report of Humana Incorporated stated, "Our strategy is to concentrate on building or buying high quality hospitals in prime markets."

By the mid-1970s, state and federal governments became concerned ut the rising cost of hospital care. The rapid capital expansion of 1960s and the early 1970s, growing consumer demand for more and ter services, and the emergence of large proprietary hospital chains hed annual hospital cost increases well beyond the general rate of flation. Many states imposed some form of rate regulation.

By the late 1970s - early 1980s, many economists argued that rate gulation was not cost effective and it didn't protect the public. is thesis was central to the Reagan Adminsitration's economic ilosophy. Deregulation became one of the primary objectives of the ministration. The Administration found deregulating the airline and ucking industries relatively easy. They found deregulating the spital industry a more difficult task. The prospective payment stem was an attempt to deregulate the hospital sector. It replaced e cost-based rate setting system, common to the public utility rate tting methodologies, with a single price for service. Its goal was move hospitals into the competitive market.

The supporters of this system argue that hospitals operating like fficient businesses and shortening patient stays will make money. ospitals that are not efficient businesses and that can't shorten ength of stay will lose money. The efficient and most competitive ospitals will simply take over the inefficient and less competitive ospitals. The hospitals that survive will be competitive money-making nterprises.

Incorporating capital into a single price for hospital services is simply the logical extension of a system that views hospitals primarily as businesses. Some hospitals may make money under this system. The vast majority of the hospitals in this country will lose. Inner-city and rural hospitals will suffer the most under this system. Often times, even the most efficient rural hospitals lack sufficient volume to generate a reasonable cost per unit of service. Under the proposed pricing formula few rural hospitals would be competitive and even fewer investors would consider financing a rural hospital capital budget. Inner-city communities face similar problems. At present, many inner-city hospitals are unable to secure adequate financing. Few investors view inner-city hospitals as a good investment. The cost of non-reimbursed services to the poor and the medically indigent has hurt the financial viability of many of these hospitals. Ironically, their financial condition makes them ineligible for federal subsidized loan programs, such as FHA-insured mortgages, or the Government National Mortgage Association (GNMA). The financing that an inner-city hospital is able to secure is often short-term and costly.

Basic Principles for the Incorporation of Capital into Medicare PPS

Although any system that creates a single price for hospital services has many disadvantages, we realize that Congress cannot ignore this issue. If Congress does not enact legislation, many believe that the Secretary has the authority to incorporate capital cost reimbursement into the prospective pricing system through regulation.

elieve that this issue must be addressed through statute and not ugh regulation. Therefore, we again urge Congress to repeal the etary's authority to adopt a new capital cost reimbursement system ugh regulation.

While the present Medicare "pass-through" of capital costs has eral inherent flaws, the incorporation of capital costs into a gle price is equally flawed. The proposed solution is surrounded by troversy and we have little idea about the long term effects of this icy. For this reason, we again believe that Congress should delay ing on this issue for one more year.

When Congress acts it should be mindful of several basic nciples.

1) While there may be a great temptation to cut the federal budget deficit by reducing Medicare capital payments, any new methodology must not be used as a vehicle to achieve budget savings.

2) There must be a reasonable transition. The transition to a federal rate for building and fixed equipment must be at least 12 years, and the transition for movable equipment must be at least 5 years.

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3) The federal portion of the capital rate must be based on data for the most recent 12 month period prior to the effective date of the new methodology.

4) The hospital specific portion of the capital rate must be based upon each years actual expenditures.

5) The capital rate must recognize the additional cost of graduate medical education, as well as the additional costs to hospitals that serve the medically indigent.

6) A new capital cost methodology must be coupled with a repeal of section 1122, and a federal pre-emption of state assessment of Medicare revenues for the purposes of creating a state operated capital funding pool.

7) A new methodology must provide for exceptions and exemptions especially for inner-city and rural hospitals. In addition, it must make special provision for facilities that recently undertook capital projects.

8) A new methodology must recognize the distinction between old capital and new capital. Old capital must be defined as capital already expended or for projects under construction prior to the effective date of the new methodology.

9) A new methodology must recognize regional differences in construction costs.

Finally, any federal policy regarding Medicare treatment of capital expenditures must be a part of - and cannot be divorced from - a broader federal policy regarding hospital access to capital. As such, that broader federal capital policy must also include the preservation of voluntary, not-for-profit hospital access to tax-exempt bond financing as well as the continuation of federal loan guarantees under section 242 of the FHA Mortgage Insurance Program.

Summary and Conclusion

To re-emphasize our basic points, the development of Medicare capital policy is a Congressional issue and one that must not be left to regulation alone. We believe that a one year delay in implementation of this new policy would provide the time necessary to develop proposals based on fairness and equity in an atmosphere conducive to the serious consideration of public policy issues. We believe any proposal must be based on the set of principles we have outlined in this statement.

Our Association stands ready to expand on any of the issues we have dealt with here and to provide the Subcommittee any assistance they might require when they undertake policy development on this important area.

Attachment
Statement of the
Hospital Association of N.Y.S.

1986 Budgeted Capital

Budgeted Depreciation and Interest as a Percentage
of Projected Inpatient Operating Cost

February 19, 1986

Frequency Distribution of by Total Capital Percent

Range	Number	1986 Inpatient Operating Cost (millions)	Depreciation Percent	Interest Percent	Total Capital Percent
0-5%	53	$1,051.8	3.12%	0.69%	3.81%
5-7%	46	$1,171.0	4.95%	1.27%	6.21%
7-10%	65	$2,979.0	6.04%	2.33%	8.37%
10-15%	40	$1,426.7	6.90%	5.31%	12.21%
15-20%	14	$569.1	8.37%	8.41%	16.77%
20-25%	5	$139.7	11.66%	10.27%	21.93%
25-30%	1	$69.3	12.96%	16.31%	29.26%
30-35%	2	$12.4	10.20%	20.76%	30.96%
35-40%	1	$20.1	17.78%	21.32%	39.10%
40-45%	1	$22.1	24.04%	19.79%	43.83%
45-50%	1	$31.3	23.18%	22.19%	45.37%
Total	229	$7,492.6	6.13%	3.46%	9.59%

Notes: All Facilities included except for Rochester Blue Cross Region, HHC and others not reporting 1986 budgeted capital.
1984 cost data trended to 1986 using 1984 trend of 5%, 1985 trend of 4%, and cost versus trend of 2% per year.

Sources: 1986 Medicaid Rate Sheet
OHSM 1984 Rate Setting Tape

MARQUETTE GENERAL HOSPITAL
REGIONAL MEDICAL CENTER
ROBERT C. NELDBERG, EXECUTIVE DIRECTOR

March 10, 1986

Mr. Joseph K. Dowley
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth Building
Washington, D.C. 20515

Dear Mr. Dowley:

This letter is being sent in response to certain proposals being reviewed for including hospital capital costs into the Medicare Prospective Payment System. I have reviewed the various proposals from the Department of Health and Human Services, as well as the proposal from the Office of Management and Budget. I have completed a review of these proposals as they would pertain to Marquette General Hospital's operations. In my analysis, I have found that a percentage add-on to the DRG prices would adversely impact Marquette General Hospital. I think it is appropriate to review the history and operations of Marquette General Hospital to understand this dilemma.

Marquette General Hospital is licensed and operating 266 acute care beds, 40 residential Substance Abuse beds, and 12 nursery beds. As the Regional Medical Center of the Upper Peninsula of Michigan, Marquette General Hospital has been designated by the State of Michigan as the Regional Medical Center for the Upper Peninsula in the 1978 edition of the State of Michigan Health Care Plan, as well as by the State of Michigan Legislature in 1984. It is also considered as a Regional Referral Center by Medicare under the Prospective Payment System. It's service area covers 11 counties with a population of nearly 300,000 people and is 154 miles from the nearest SMSA. The Hospital's medical staff is comprised of over 100 physicians offering a wide and comprehensive range of specialties. As the Regional Medical Center, Marquette General Hospital provides, among other things, the following care and services to patients:

Medical/Surgical Care Units
Intermediate Care Unit
ICU/CCU
Oncology Unit
Neonatal Intensive Care Unit
Psychiatric Unit
Substance Abuse Unit (Acute and Residential)

Administrative Offices 420 W. Magnetic Street, Marquette, Michigan 49855 Phone (906) 228-9440 Wats Line 1-800-562-9753
Patient Services 515 W. College Avenue, Marquette, Michigan 49855 Phone (906) 228-9440 Wats Line 1-800-562-9753

Surgery, including thoracic, open heart, orthopedic, neurosurgery, plastic surgery
Complete Laboratory and Blood Bank
Cardiac Diagnosis and Surgery
Pharmacy
Endoscopy
Rehabilitation Services
Respiratory Therapy
Renal Dialysis/Hemodialysis
C.T. Scanning
Nuclear Medicine
Radiation Therapy/Cobalt Therapy
Emergency Medical Services - Ambulance equipped with advanced life support
Family Practice Residency Program

Marquette General Hospital has clinical affiliations with teaching programs at Northern Michigan University, Oakland University and Wayne State University in registered nursing, practical nursing, radiologic technology, physical therapy, and medical records technology. It is also a teaching facility of the U.P. Medical School of Michigan State University. This teaching program is designed to train family practitioners in the community that they will serve. Marquette General Hospital is the home base for 15 Family Practice Residents.

For 1985, Marquette General Hospital had 10,381 patients admitted utilizing 84,071 patient days. The hospital had total expenses of $39,513,000.

In August of 1981, we had the dedication ceremony for the new 8 story addition which houses a new surgery and recovery suite, laboratory, central sterile supply, bulk storage, emergency room, endoscopy, admitting, cafeteria, emergency medical services, and four floors of nursing units. The top four floors hold 192 beds, or 72% of the Hospital's total bed capacity. This construction has consolidated the Hospital from two facility locations to one and modernized most of the direct patient care departments. The total project cost was $21,313,000.

Most recently a new four story 60,000 square foot building was completed in 1984, at a cost of $7,482,000. A new department, Radiation Therapy, is located in this new structure occupying the ground floor. This department provides

cancer treatment by utilizing state of the art equipment such as a linear accelerator, simulator, computerized treatment planning, superficial therapy, and also a cobalt therapy machine. This equipment cost $1,070,000.

The fourth floor of the new building houses an expanded inpatient acute Psychiatric Unit, the only such unit in our service area. Hemodialysis occupies the second floor and is one of only two units in our service area. Also located on the second floor is Endoscopy Department, with 10 treatment rooms. The Library and Education departments are on the third floor. Furthermore, conference rooms are available on the third floor, providing much needed space for meetings, conferences and education for physicians, residents, staff and patients.

It should be mentioned that the appropriate review approvals have been obtained from Michigan Department of Public Health and 1122 Review for all of our new building programs.

In conjunction with the building projects mentioned above, Marquette General Hospital has purchased needed medical equipment to provide up to date technology to the residents of Upper Michigan. Since 1980 Marquette General Hospital has purchased over $7,000,000 in equipment.

Regional Medical Centers such as Marquette General Hospital are more capital intensive than other hospitals. Marquette General has added such sophisticated medical equipment as the C.T. Scanner, the Linear Accelerator, digital subtraction angiography, sophisticated ultrasound and laboratory equipment, heart catheterization equipment, ICU/CCU monitors, and equipment necessary for open heart surgery. Equipment purchasing is a dynamic process. Plans are currently underway to seek approval for purchasing an additional C.T. Scanner for $953,000, as well as a Magnetic Resonance Imaging Building and equipment, at a cost of $3,189,000.

Most of the financing of this equipment and building projects have been from internal depreciation reserve funds. However, some of the financing was accomplished through tax exempt financing. As of June 30, 1985, Marquette General Hospital had $20,730,000 in outstanding long term debt. The last of these bonds would mature in the year 2007.

As mentioned above, I have completed a detailed analysis of the pending Medicare Capital Proposal as it would affect Marquette General Hospital. I have used a 6.89% add-on to each DRG for payment of capital costs. In looking at our current fiscal year 1986 data, we anticipate having interest expense of $2,075,000, fixed depreciation of $2,012,116, and moveable equipment depreciation of $1,027,784. This adds up to a total capital cost for fiscal year 1986 of $5,114,900. Medicare's portion of these capital costs would be $2,122,684. The current capital proposal now being reviewed would reimburse us only $980,244 on Medicare's portion. This means that Medicare would only pay for 46% of the capital costs that pertain to the Medicare program. This would leave us a shortfall of $1,142,440, to be made up from other carriers or our own reserves. Clearly, you can see that this would be a major economic shortfall to our hospital.

Nearly 80% of our capital costs are long term. As mentioned before, our bonds do not mature until the year 2007, and 2/3 of our depreciation is on buildings or long term fixed equipment. All of these building projects or equipment purchases have been appropriately and previously approved by the necessary agencies. Our hospital does not seek to derive profit on capital cost reimbursement from Medicare, only to recover costs. If this proposal becomes a reality, not only would we be unfairly reimbursed for capital costs of previously approved projects, but it would severely stifle the future acquisitions of needed technology for the residents of the Upper Peninsula of Michigan. I urge you to take the above information into account as you proceed with the process of reviewing the Medicare capital proposal. I feel that up to this point inadequate attention has been paid to the specific and unique capital needs of a regional medical center. If you have any questions regarding this paper, or would like our assistance in your review, we would be happy to assist and cooperate with you or your staff.

Sincerely,

Don Grisham

Don Grisham, CPA
Assistant Administrator
for Finance
Marquette General Hospital

STATEMENT OF THE

MASSACHUSETTS GENERAL HOSPITAL

I. INTRODUCTION

The Massachusetts General Hospital (MGH) appreciates this opportunity to provide its view on the issue of Medicare capital reimbursement. The MGH recognizes that it has to be responsive to the broad societal concerns over the cost of healthcare and in particular to the national priority setting inherent in the Congressional and Administrative budget process. We believe that as the tide has turned over the past few years away from cost based reimbursement, that the MGH has been responsive to cost containment pressures. The MGH has reduced its workforce by more than 493 people (7.3% of the workforce) since 1982. This has been accomplished while maintaining high occupancy both within the general population and within the Medicare population as well. We are particularly concerned that various Medicare capital reimbursement proposals will cause the MGH to be paid in excess of $30 M less than its costs over the period of 1990 to 1999. Our projections are based on the impact of the Administration's Medicare capital proposal on the facility replacement program that MGH is currently embarked upon.

In the following paragraphs, we will expand upon the MGH's particular situation and close by recommending that some form of hold harmless provision be incorporated into the Medicare capital proposal that will deal with the particularly problematic situation of a well utilized, vital institution being caught between the need for capital replacement and the law of averages.

II. THE MGH

The Massachusetts General Hospital has provided continuous service to patients from the same location in the West End of the City of Boston since 1821. As an acute care teaching hospital, it

is authorized to operate 1,082 beds and provides a full range of inpatient and outpatient services with the exception of opthalmological and otolaryngological services (which are provided by the adjacent Massachusetts Eye and Ear Infirmary) and inpatient obstetrics. In fiscal year 1985, the hospital cared for 32,136 admissions and 604,747 outpatient visits. Because the hospital does not provide inpatient obstetrics or ENT services which generally have short lengths of stay, its average length of stay was 10 days in 1985. The average length of stay has declined 1.4 days over the past five years.

In 1985, over $18 M in uncompensated care was provided to patients who either could not pay or could only pay for part of their services.

In addition to its significant patient care responsibilities, Massachusetts General Hospital is a major component of our nation's medical education and medical research capabilities. The hospital is currently training 416 residents in 17 residency programs, with additional trainees in clinical and research fellowships. The hospital has over 1,000 full time employees engaged in research activities supported by non-patient related funds.

The MGH has been the site where many firsts and early development of patient care methods have taken place.

1956	Developed Respiratory Intensive Care following polio epidemic
1960	Reattachment of severed limbs
1970	Freezing and storing of blood
1975	Computerized Tomography developed (second one in US).
1984	Magnetic Resonance Imaging (early development)
1984	Lithotripsy introduced in US (second site)
1985	Artificial skin developed

III. UTILIZATION AT MGH

The MGH's occupancy percentages are as follows:

	Beds in Service	Occupancy
1982 Actual	1,092	87.68%
1983 Actual	1,086	84.78%
1984 Actual	1,081	84.34%
1985 Actual	1,050	83.67%
1986 Year-to-Date	978*	85.03%
1995 Projected	977**	89.43%

*Renovation of existing beds caused beds to be temporarily of out service.

**Permanent bed reduction in accordance with replacement project

The MGH's Medicare population is as follows:

	Medicare Days	% of Total
Days		
1982 Actual	140,005	40.3%
1983 Actual	138,629	41.3%
1984 Actual	135,533	40.7%
1985 Actual	121,954	38.2%
1986 Year-to-Date December	32,344	42.6%
1995 Projected	129,878	40.7%

As the 1995 bed numbers indicate, we have as part of our capital planning process agreed to reduce the MGH's licensed beds from 1,082 to 977, a 9.7% reduction.

IV. CAPITAL SITUATION

While the Massachusetts General Hospital has a long and distinguished history in patient care, medical education, and biomedical research, the hospital's physical plant is very old and

in need of both major replacement and remodeling. The hospital consists of six inpatient buildings. A 1940 building is presently being extensively renovated and a 1969 building is able to support contemporary medical practice requirements. Buildings presently used but built in 1948, 1930, 1917, and 1821 are obsolete and contain significant life safety code violations. In 1979, it was agreed by the Trustees of the hospital to give top priority to the development of a program to replace these facilities. After a year of intensive planning, a fund raising effort was initiated in February of 1981. The hospital plans to raise $100M in private donations of which over half has already been pledged or received. In addition $141 M has been borrowed through the Massachusetts Health and Educational Facilities Authority. When the project is completed, the hospital estimates capital costs for depreciation and interest will equal approximately 14% of the total general fund expense.

V. PROJECT TIMING

The construction process will take seven years to complete because the available site is surrounded by four in-patient buildings which must remain in operation while the first patient tower is erected. It is then proposed that one of the old patient buildings adjacent to the new tower be demolished and a second tower be built in its place. Following that, two more of the old patient buildings will be demolished which will then allow a low rise (five level) building to be constructed around the base of Tower One.

VI. FINANCIAL IMPACT OF POTENTIAL MEDICARE CAPITAL REVISIONS

As the hospital plans this major facility replacement, attention is directed at its past and future financial environment. By direction of its Board of Trustees, the hospital has traditionally set its prices to only barely recover costs. The hospital is also in a highly regulated state where patient care revenues are subject to review and regulation. As a result, the

hosptal had a 1985 operating profit of $2.4 million on operating expenses of $297 million. In the prior year, the hospital earned $1.9 million on operating expenses of $279 million. Essentially the hospital has operated at a "break-even" level.

The MGH was under a waiver of Medicare regulations until October 1985. The hospital's budget for 1986 contemplates receiving approximately $86 M in total Medicare payment. This amount is a reduction of approximately $3M from the total Medicare payments received in 1985 under the waiver agreement. The hospital had to reduce its operating budget in 1986 by some 3% in constant 1985 dollars to meet the fiscal pressure from Medicare and its other payors. The point of this data is to reinforce the fact that MGH is not in a substantial surplus position either in aggregate or by reason of the PPS payment system. As we face the potential changes in Medicare capital reimbursement, we start out financially even after responding to three consecutive years of cost pressures in which the all payor experiment extracted various degrees of cost reduction below a hospital market basket level of inflation as is evidenced by our 7.3% workforce reduction during these years.

The analysis of the impact of the Medicare capital proposals is based on the following assumptions:

o The Medicare inpatient capital fixed payment will be approximately 8.5% of the National urban per case rate.

o This rate will be adjusted solely for case mix intensity.

o The hospital will realize approximately $6.3M of operating cost savings when the project is complete. These savings are offset against the impact of the fixed Medicare capital payment.

Table I presents the analysis of the year 1990 (when the first element of the project is capitalized) through the 10 years out to 1999.

MASSACHUSETTS GENERAL HOSPITAL
TABLE I
ANALYSIS OF MEDICARE CAPITAL PAYMENT
1990-1999
(Stated in Constant 1985 Dollars, $000 Omitted)

	1985 [1]	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	CUMULATIVE NET LOSS
OPERATING EXPENSE	$274,979	$268,218 [2]	$268,218	$268,218	$261,845 [5]	$261,845	$261,845	$261,845	$261,845	$261,845	$261,845	
EXISTING DEPRECIATION	14,532	16,257	16,000	16,000	15,737	16,000	16,013	16,000	16,000	16,000	16,013	
EXISTING INTEREST	7,280	6,275	5,700	5,300	5,163	4,800	4,618	4,500	4,300	4,100	4,000	
PROJECT DEPRECIATION	-	4,000	4,000	4,000	7,732	7,732	7,732	7,732	7,732	7,732	7,732	
PROJECT INTEREST	-	7,507	7,507	7,507	12,512	12,405	12,287	12,152	12,008	11,855	11,495	
TOTAL CAPITAL	21,812	34,039	33,207	32,807	41,144	40,937	40,650	40,384	40,040	39,687	39,240	
TOTAL EXPENSE	$296,791	$302,257	$301,425	$301,025	$302,989	$302,782	$302,495	$302,229	$301,885	301,532	$301,085	
COST BASED MEDICARE [3] INPATIENT PAYMENT		7,628	7,442	7,352	9,220	9,174	9,110	9,050	8,973	8,894	8,794	
FIXED MEDICARE INPATIENT [4] PAYMENT		4,520	4,520	4,520	4,520	4,520	4,520	4,520	4,520	4,520	4,520	
LOSS		(3,108)	(2,922)	(2,832)	(4,700)	(4,654)	(4,590)	(4,530)	(4,453)	(4,374)	(4,274)	
OPERATING SAVINGS RETAINED [6]		-	-		1,428	1,428	1,428	1,428	1,428	1,428	1,428	
NET LOSS-MEDICARE ONLY		(3,108)	(2,922)	(2,832)	(3,273)	(3,226)	(3,162)	(3,102)	(3,025)	(2,946)	(2,846)	(30,442)
FIXED CAPITAL PAYMENT IF ALL PAYORS FOLLOW MEDICARE [7]		22,527	22,385	22,317	23,734	23,699	23,650	23,605	23,546	23,486	23,410	
NET LOSS-ALL		(11,512)	(10,822)	(10,490)	(12,122)	(11,950)	(11,712)	(11,491)	(11,206)	(10,913)	(10,542)	(112,760)

1--Ties to financial statements
2--Represents approximately 3% constant dollar cost reduction carried out in 1986 then held constant
3--Based on 83% of capital being patient related and 27% by Medicare inpatient
4--Based on previously stated assumptions
5--Represents projected operating cost changes associated with project
6--Recognizes that under fixed DRG payment, operating savings are retained (Medicare inpatient share)
7--Grossing up patient related payment and adding non-patient at cost, net of savings

VII. RECOMMENDATIONS

As the Table I analysis demonstrates, Medicare payments for capital as currently proposed will result in a shortfall of significant proportions when measured against the hospital's costs even after applying the operational cost savings contemplated in the newer more efficient facility. This is the unfortunate consequence of our institution being at a point on the natural capital replacement cycle when its capital costs will reach a level greater than the average of other institutions.

We recommend that we not be put at risk in this situation. The most practical solution would appear to lengthen the transition period from hospital actual dollars to fixed payment rates, or to linking fixed payments to a schedule that is based on the age of the hosptal's assets and degree of debt financing. Alternatively we propose a formula to allow special consideration to institutions who have made substantial and irrevocable capital commitments which current Medicare capital proposals would endanger.

We at MGH would be happy to provide any other data necessary to clarify our position and situation.

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STATEMENT OF LARRY S. GAGE
President and General Counsel
National Association of Public Hospitals

February 24, 1986

Subcommittee on Health
Committee on Ways & Means
United States
House of Representatives

Mr. Chairman, members of the Subcommittee, I am Larry Gage, President and General Counsel of the National Association of Public Hospitals. NAPH consists of 60 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

I am particularly pleased to have this opportunity to submit testimony to the Ways and Means Health Subcommittee again today, because the NAPH greatly appreciates the attention your Subcommittee has paid in recent years to the many difficult and important health care issues confronting "disproportionate share hospitals." We are especially grateful for your attention to the needs of such hospitals in the context of current efforts to reduce Medicare payment levels to hospitals generally, and major teaching hospitals in particular, in the pending Budget Reconciliation Act Conference Report.

We welcome the opportunity to provide you with our observations regarding current proposals concerning how capital costs should be paid for under the Medicare program. In this prepared statement, NAPH will respond in particular to the Administration's proposal that capital payment amounts be incorporated by regulation into the non-labor portion of Medicare prospective payments during a four-year transition period.

We will discuss this proposal in a broader context, however, because we believe it is important for the committee to

understand and appreciate the extremely precarious capital situation of many NAPH members and other essential providers of care to the poor.

For example, a superficial analysis might indicate that large, metropolitan area public hospitals as a group receive the lowest average capital pass-through of any category of hospitals in the nation -- less than 4%, as compared with about 7% nationwide. However, a closer look will reveal that this is due in large part to the older, more deteriorated physical plants of such hospitals. Hospitals in that condition might therefore realize a "windfall" in the short run from rapid implementation of a 7% capital add-on to Medicare/PPS payments. In the long run, however, such hospitals would more likely experience greater deterioration in their ability to make future capital expenditures necessary to enable them to continue filing their unique and valuable "safety net" role. I believe we all agree that this role is a necessary and appropriate one, particularly at a time when increased competition throughout the nation's health system continues to increase pressure on hospitals serving low income patients. For this reason, our basic position on Medicare capital payments is this: whatever action you may take regarding such payments for the hospital industry generally, we believe you must provide some measure of additional flexibility, perhaps on a case by case basis, to address the special needs of such hospitals.

Finally, we believe it is important for the Committee also to appreciate that other Congressional and regulatory actions this year can also have an impact on the ability of urban public hospitals to gain access to capital. These include tax reform and the increasing need for additional credit enhancements, such as under the FHA hospital mortgage insurance program.

Although Medicare payments of capital play a significant role in the capital financing situation for hospitals, Medicare's treatment of such costs is only one part of a much larger picture. A signal feature of this picture over and above the issue of reimbursement, is access to capital, whether such access it is obtained through tax-exempt financing, or through credit enhancement programs, such as the Hill-Burton program or FHA mortgage insurance under §242 of the National Housing Act. Several of these issues are also within the jurisdiction of your Committee, and tax exempt financing in particular will again be under active consideration by your Committee as part of H.R. 3838 if the Senate passes tax reform and you go to conference. We would like to provide you with our observations on these issues as well, as part of our overview of the capital situation of NAPH members today.

For these reasons, the remainder of my testimony this morning will be divided into three sections: Section I will describe the capital characteristics and capital needs of NAPH members and other public hospitals generally, including a comparative analysis of the current Medicare capital reimbursement received by such hospitals. Section II will provide several specific examples of the capital situation of particular NAPH member hospitals. Finally, Section III will provide our specific comments on Medicare capital reimbursement, and other capital-related issues affecting public hospitals today.

I. Capital Characteristics and Capital Needs of Public Hospitals

It is generally acknowledged that the hallmarks of public hospitals -- serving a high number of indigent patients, relying

on major support from public sources of revenue, operating older and, at times, obsolete physical plants, and failing to have an overall competitive "attractiveness" to patients and private payers -- are also formidible obstacles in obtaining access to capital. The investment community has historically eschewed institutions with such profiles, absent governmental guarantees or other credit enhancements. However, traditional public sources of capital financing (e.g., general obligation bonds, state or local appropriations) have become far more unreliable due to the relatively greater fiscal weakness of many localities, increased demands for taxpayer and community dollars, and in some cases, outright taxpayer revolt. And all the while, many urban public hospitals see a greater proportion of low income patients, face increasing deficits and grow older and older.

What is the current financial situation of public hospitals with regard to capital? What role have Federal programs played in supporting capital initiatives? What sources have public hospitals used to support capital? What are the capital needs of these facilities and what does the future portend for financing of their capital improvements? The following sections identify the capital situation of urban public hospitals and consider their capital requirements for the remainder of this century. The information presented here is based upon a small but reliable sample of large urban public hospitals, re-verified through 1984, the latest date for which information is available.

A. Capital Financial Characteristics of NAPH Members

TABLE I presents financial ratios and other selected financial characteristics affecting hospitals' ability to obtain access to sources of capital. Comparisons of critical indicators of capital "attractiveness" confirm the assertion that public

hospitals are in a uniquely precarious position and are at a severe disadvantage when competing for funds in the capital marketplace.

1. Age of plant. The average age of an NAPH member's physical plant is 12.5 years (TABLE I). This average is well above the Council of Teaching Hospitals (COTH) average of 7.4 years - a group that also includes the majority of NAPH members - as well as the non-COTH average of 6.7 years. In fact, when NAPH is compared to COTH and non-COTH hospitals by census region, the NAPH member's average plant age exceeds every area and every hospital average in the country (TABLE II). This substantial age difference reinforces the belief that many of the large urban public institutions are in a singularly serious situation with regard to their capital needs.

2. Ratios of current assets to liabilities. The ratio of current assets to liabilities (i.e. the current ratio) is often used as one of a number of indicators of hospital attractiveness in the bond market. For example, Standard & Poors has determined that a hospital with less than average current assets to liabilities have ratios below 2.0. NAPH members average 1.9, indicating relative non-liquidity of funds, and symptomatic of the financial stress they suffer.

3. Maximum debt service coverage. TABLE I identifies NAPH members' maximum debt service coverage, which represents current capacity to carry their debt. Six of the 10 members responding identified a ratio of 2.0 or less.

According to investment analysts, hospitals whose maximum debt service coverage is roughly 2.0 or less would fall into a A- or lower bond rating. These hospitals would have "no real market" for obtaining capital, and would need mortgage insurance

or some other assurance to support their profile. Thus, 6 of the 10 responding NAPH members would require such support.

4. Ratio of debt service to gross patient revenues. NAPH members' debt service to gross patient revenue ratio averages 2.9%, indicating that there is not much debt outstanding. In theory, it could mean that they could take on capital projects. However, these facilities, in general, are often very old due to their previous inability to obtain capital support. That is, public hospitals often cannot find sources willing to finance debt for capital. The result is an old plant that cannot be renovated.

TABLE I

Selected Financial Characteristics of NAPH Members - 1983

Average Age of Plant	12.5 years (20 hospitals)
Ratio of Current Assets to Liabilities	1.9 (average) (22 hospitals)
Ratio of Debt Service to Gross Patient Revenues (expressed as a percent of gross patient revenue)	2.9% (average) (15 hospitals)
Maximum Debt Service Coverage	Average: 2.6 range: -2.1 to 8.7 (10 hospitals)

TABLE II

Average Plant Age (in years) in Short Stay Non-Federal Hospitals by Membership in COTH and Census Region, 1982

	Average Age of Plant*	
	COTH Hospitals	Non-COTH Hospitals
New England	8.74	8.16
Middle Atlantic	8.00	7.53
South Atlantic	7.04	6.19
East North Central	6.81	7.17
East South Central	7.32	6.22
West North Central	7.51	7.21
West South Central	6.74	6.01
Mountain	5.80	6.05
Pacific	7.74	5.99

* Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Annual Hospital Survey

Excerpted from: J. Bentley, "Toward an Understanding of Capital Costs in COTH Hospitals", 1984.

B. Capital Reimbursement under Medicare and Medicaid

TABLE III identifies 1983 Medicare and Medicaid depreciation reimbursement (i.e. depreciation of capital assets) and debt principal payments (i.e. payments for new investments) to NAPH members. As expected, average depreciation reimbursement to members was substantially higher for both programs than were debt principal payments. These public hospitals averaged $790,000 in Medicare depreciation reimbursement and $730,000 in Medicaid depreciation reimbursement. Debt principal payments, however,

were very low, averaging $30,000 per hospital for Medicare and $40,000 for Medicaid, including 18 hospitals that reported "zero" reimbursement for debt principal payments.

NAPH members differ dramatically when these findings are compared to other sectors of the hospital industry. A 1982 report (Kinney and Lefkowitz) investigated the relationship of Medicare and Medicaid depreciation reimbursement to debt principal payments (See TABLE IV). As indicated, proprietary hospitals represented the greatest proportion of debt principal to depreciation payments, 81.8%, ($90.0 million/$110 million), followed by voluntary hospitals, 50.48% ($530 million/$1,050.0 million); public hospitals demonstrated the lowest proportion, 25% ($60.0 million/$240 million). However, NAPH members' debt principal/depreciation reimbursement, is substantially below these levels: 4.7% ($1.7 million/$36.5 million).

Recent studies confirm the extreme situation of urban public hospitals. For 1983, capital costs accounted for 7% of Medicare reimbursements to hospitals in general. Payments to public hospitals with over 400 beds averaged 3.9% overall, lower than any other category measured (Anderson & Ginsberg).

TABLE III

Medicare and Medicaid Capital
Reimbursement to NAPH Members - 1983
(in millions)

	Medicare		Medicaid			
	Total	Avg.	Total	Avg.	Total	Avg.
Depreciation Reimbursement No. of hospitals 24	18.90	.79	17.62	.73	36.52	1.51
Debt Principal Payments No. of hospitals 24*	.75	.03	.96	.04	1.71	.07

* 18 hospitals reporting Medicare and Medicaid reimbursement indicate no debt principal payments accrued.

What are the implications of these findings for large city public hospitals? More than any other group, these institutions' assets are the oldest while their investment in new capital is extremely low. And while the availability of discretionary funds for proprietary and not-for-profit hospitals represents monetary support for additional capital expansion and investment, the public hospitals "discretionary" funds are most often used for other purposes, in particular to cover operating deficits resulting from providing high amounts of bad debt and charity care.

TABLE IV

Estimated Depreciation Reimbursement and Debt Principal Payment by Type of Community Hospital, FY 1981 ($ in millions)

	Voluntary	Proprietary	Public	All Community Hospitals
Total Medicare and Medicaid Reimbursement	22,700	2,470	6,080	31,250
Depreciation Reimbursement	1,050	110	240	1,400
Debt Principal Payment	530	90	60	680
Difference Between Depreciation and Debt Principal (Discretionary Funds)	520	20	180	720

Sources: AHA, Hospital Statistics, 1980 Edition and AHA, 1977 Annual Survey (Unpublished Data).

Excerpted from: E. Kinney & B. Lefkowitz, "Capital Costs to Community Hospitals under the Federal Health Insurance Programs." Journal of Health Politics, Policy and Law, 1982.

C. Funding For Capital Initiatives

NAPH members, like other sectors of the hospital industry, have relied primarily on debt to finance capital construction and renovation. Long-term debt accounted for for more than half of the more than $200 million obtained by these public hospitals. NAPH members also relied on local governments and internal funds for supporting almost $100 million in capital projects. Philanthropy and Federal government sources by far contributed the least to member capital funding.

D. Debt Financing of Capital

Don Cahodes has reported a substantial increase in financing of capital through tax-exempt public offerings from 1973 (36.2%) of financing) to 1979 (80.6%). Private placements, conventional mortgages, government sponsored programs and taxable public offerings have all deceased dramaticallly during that period.

For NAPH members, although debt financing information is incomplete, the importance of tax exempt public offerings, as identified by Cahodes, is evident. For the three years examined, NAPH members identified a total of more than $200 million in tax exempt public offerings - more than three-quarters of all debt financing reported (private placements were a distant second). And in 1983 this mechanism represented almost 90% of debt financing. Of critical importance during these years, however, is the decrease in taxable public offerings and the virtual absence of support from almost all other sources. For example, in 1983 none of the reporting hospitals identified financing through taxable public offerings, while two hospitals had obtained financing through conventional mortgage loans or Federal government programs for a total of only $600,000. Thus, members'

access to debt financing, in general, has been confined to what the tax-exempt mechanism, and, to a lesser extent, private placements, have allowed.

E. Capital Needs of NAPH Member Hospitals

NAPH members who responded to the request for information on capital needs identified in the aggregate at least $900 million (TABLE V) over the near term. Almost 84% of these needs were related to basic building construction and renovation, including the following: a trauma center, a surgery building, all or a major part of a hospital (5 hospitals) an ancillary services facility; a children's clinic; and pediatric and neonatal intensive care units. The estimated building needs approach $40 million per member.

Equipment need estimates approach $140 million for 21 hospitals, and include radiology and laboratory equipment, CT and NMR equipment, operating room tables, anesthesiology systems. Comparatively little funding is forseen for land (total $6.3 million).

Although the $900 million total recognizes that substantial capital need exists at NAPH institutions, it is essential to recognize that these estimates underrepresent significantly the total capital needs of NAPH members since many hospitals list only capital projects that are likely to be funded over the next few years. Public hospitals demonstrated the lowest rate of increase in capital expenditures (5% for a five year period from the mid to late 1970s), when compared to voluntary facilities (15.6%) and proprietary institutions (12.1%) (Kinney & Lefkovitz), 1982). Moreover, some NAPH members who require a total or major renovation/reconstruction of their physical plants did not list or estimate the projects on their "wish lists" since funding will not occur.

TABLE V

Estimated Capital Needs of NAPH Members through 1988
(in millions)

	Total	Average
Building No. of hospitals: 19	$731.1	38.5
Moveable Equipment No. of hospitals: 21	$136.1	6.5
Land No. of hospitals: 4	$ 6.3	1.6
Total	$873.5	

II. EXAMPLES OF THE CAPITAL SITUATION OF SPECIFIC NAPH MEMBER HOSPITALS

Unlike so many other hospitals, essential providers of care to the poor, such as NAPH members, typically do not require capital financing merely to install major medical equipment which represents the latest trend in technology, nor to embark on the cosmetic changes needed to create a competitive, "upscale" facility. These hospitals are, instead, attempting to address severe structural deficiencies, often which threaten the hospital's very accredition and patient safety. Furthermore, these projects typically do not expand bed capacity. Instead they carry out the best health planning objectives: downsizing inpatient capacity in favor of more cost-effective ambulatory care; sharing technology and resources among facilities; and other innovations to provide more efficient care within a limited operating budget.

A. California County Hospitals - 1984 Survey Data

Recently, NAPH surveyed member county hospitals in California to obtain a more concrete picture of their capital

needs. This survey found that 6 county hospitals needed complete replacement at a total cost of $742.7 million (one hospital required complete replacement at a cost of $370.0 million).

These replacements were required for several reasons, including:

- o old and outdated facilities were not cost-effective to maintain; and
- o numerous deficiencies were cited by license and accreditation agencies as well as grand jury citations, agencies rendering the hospital noncompetitive.

Examples of those deficiencies include: surgical suite with inadequate ventilation; old flooring that had become an infection hazard; improving emergency back-up systems.

Of the estimated $262.0 million needed for partial renovation, expansion and equipment, about $65.0 million were related to JCAH, grand jury or state citations (e.g. installing air conditioning on impatient units, adding bathrooms, increasing electrical capacity).

Over $120 million were identified as necessary to meet increased service requirements and service system efficiencies (e.g. responding to increased demand for OB/GYN and neonatal services; expanding patient waiting areas; removing asbestos; replacing or expanding sewer lines).

Outpatient capital improvements totalled $122.7 million, including $29.8 million for total out patient replacement.

B. Other NAPH Member Hospitals

1. PARKLAND MEMORIAL HOSPITAL

Parkland Memorial Hospital is the major public hospital in Dallas, Texas. During 1983, this 821-bed facility maintained an occupancy rate of 82% and admitted almost 36,000 patients. Parkland also provided 267,000 outpatient visits and 167,000 emergency room visits. In 1983, Medicare represented 12.5% of $246.6 million in gross revenues at the hospital. Private insurance and Medicaid accounted for, respectively, 13.3% and 5.5% of these revenues, and city and county appropriations covered most of the remaining 68.7%.

Parkland's 1985 Medicare capital payment of $2.1 million equalled 13.0% of total actual Medicare reimbursement. Capital renovations exceeding $80.0 million are currently underway, involving a large part of the hospital as well as a replacement of equipment. Still, projected five-year capital needs for equipment, parking and other programs exceed $65 million.

2. COOK COUNTY HOSPITAL

Cook County Hospital is a public institution with over 1200 beds in Chicago. With a 68% occupancy rate, it accounted for almost 41,000 inpatient admissions in 1983. During that year, Cook County provided 375,000 outpatient visits and an additional 289,000 emergency room visits. Medicare represented 10% of the $212.2 million in revenues, with an additional 34% covered by Medicaid and private insurance. City and county appropriations accounted for over 50% of the revenues for the hospital. Cook County's Medicare capital payments during 1985, $.44 million, equalled only 1.8% of total Medicare reimbursement for that year. However, the capital needs at the institution are substantial. A

replacement hospital may be needed in the near future, and while such a hospital would undoubtedly be smaller in scope than the present facility, the costs would still be substantial. Even without a replacement hospital, Cook County will require at least $33 million to renovate the existing 1913 facility's various services, including adult and pediatric emergency rooms, cardiac laboratory, and trauma unit improvement.

3. GRADY MEMORIAL HOSPITAL

Grady Memorial Hospial is the major public hospital in Atlanta, Georgia. With 1012 beds and 78.5% occupancy rate in 1983, Grady had over 45,000 admissions, 482,000 outpatient visits and 258,000 emergency room visits. Medicare accounted for 21% of the $112.6 million in 1983 revenues. Medicaid and private insurance represented, respectively, 22.4% and 11.1% of the revenues for that year.

During 1984 Grady received $1.15 million in Medicare capital payments, or 3.6% of the $32 million in total Medicare Reimbursement. While renovations during the previous five years have been relatively minor (e.g., $2.5 million for radiology, $1.5 million for laboratory equipment and facilities), the hospital estimates that $125 million will be required in the next few years for major renovations (e.g., reducing eight-and four-bed wards, building stairwells required by JCAH, installing bathrooms and adding needed clinics).

4. BOSTON CITY HOSPITAL

Boston City Hospital (BCH) is the major urban public hospital serving residents of the city. During 1983, with 541 beds and an occupancy rate of 79%, discharges totalled 16,593. BCH also provided 139,415 outpatient visits and 73,232 emergency

oom visits in 1983. Medicaid was the primary payer, epresenting almost 50% of the $83.7 million in revenue for that ear. The remaining revenue sources included private insurance 25%), Medicare (15%), city subsidy (4%) and other programs (6%).

For 1984 Medicare capital payments equalled 6.3% of the otal $25.4 million in Medicare reimbursement. While only $19.5 illion in capital expenditures occurred over the past five ears, a substantial portion was related to life safety code iolations (e.g., sprinkler system, fire doors). BCH estimates, ue to serious infrastructure problems, that $175 million for a ajor rebuilding program needs to be expended, starting in two ears.

5. WISHARD MEMORIAL HOSPITAL

Wishard Memorial Hospital is the major public hospital in ndianapolis, Indiana. During 1983, this 557-bed facility had a 3% occupancy rate and admitted 17,600 patients. It also rovided almost 276,000 outpatient visits and 75,000 emergency oom visits. State and local government is the major source of e $137.6 million in hospital revenues followed by Medicare .9%). Revenue from Medicaid and private insurance were 14% and 2% respectively, with nonspecified revenue making up the fference.

Wishard's 1984 Medicare capital payment of $1.2 million was arly 5% of total Medicare reimbursement. Capital renovations ring the past five years totalled $11.5 million and included boratory renovations and establishing an ambulatory surgery nter. Wishard has projected estimated capital expenditures of 0.7 million for additional renovations and equipment in the mediate future.

III. Discussion of Legislative Proposals

To summarize our position on current Medicare capital payment proposals, NAPH strongly opposes the Administration's effort to adopt regulations to phase capital payments into PPS payments quickly, over just four years, with the expectation of significantly reducing those payments by upwards of $4.2 billion in the next three years. We are particularly concerned that such an approach is a recipe, not for a "reform" of capital cost reimbursement, but for its outright demise in what has become an annual budget-driven debate over Medicare hospital payment increases. In testimony before the House Ways and Means Committee, DHHS spokesman Robert Helms suggested that this proposal promotes "flexibility," "predictability" and "efficiency." However, we would note that "predictability" is no help if the payment levels are inadequate. Also, as noted above, public hospitals have typically had no choice but to be efficient users of new capital, generally reducing the size of their physical plant, often postposing needed repairs if their publicly funded budget is tight, generally reducing the size of their physical plants when conducting major renovations, and purchasing only minimally necessary new equipment or technology. Additional "incentives" like reduced reimbursement are hardly likely to generate greater "efficiencies" than the current budget process and capital constraints already faced by such hospitals.

In conclusion, whatever approach is taken to Medicare Capital reimbursement on an industry wide basis, we would strongly recommend that additional attention be paid to the special needs of major metropolitan area public hospitals and other disproportionate providers of care to the poor. In particular, we urge you to make special provision for those "disproportionate share" hospitals which have recently

undertaken, or must in the near future plan for, major capital renovations that will be necessary to enable such hospitals to continue to perform their role as essential providers of care to low income patients. We agree that such special attention can and should be tied to increased scrutiny of the necessity for capital spending, and the scope and efficiency of the projects themselves. As governmental entities, in short, we ask you to remain in partnership with us wherever necessary to ensure the continued availability of needed governmental health services. Quite simply, competition alone will not meet these future needs -- and increased competition for paying patients will continue to erode the ability or willingness of many other providers to serve low income patients.

B. Access To Capital Markets by Essential Providers

This final section of my testimony will summarize NAPH's comments on other issues likely to affect public hospital's future ability to obtain access to capital.

As noted above, in addition to Medicare reimbursement, the NAPH capital financing agenda also includes important issues regarding the continued availability of tax exempt financing, and access to capital generally. In this final section, I will briefly summarize our observation and concerns regarding these issues.

1. Tax-exempt Bond Financing

There are several areas of concern to urban public hospitals in the tax-exempt financing provisions of H.R.3838. In addition to our comments on Medicare reimbursement, we therefore also ask that you take our concerns into account in any future conference action on that measure. Those areas include in particular:

- o definition of "governmental" hospital (and clarification of public use)
- o early issuance (5% rule)
- o expenditure of proceeds (3-year rule)
- o restricting the trade or business use of governmental bonds

a. Definition of Governmental Hospital

Bonds which provide funds for use in operating a major metropolitan area public hospital should be treated as essential function ("governmental") bonds regardless of the corporate structure of the hospital. Like many state universities, a number of large, public hospitals, for example, are organized for certain purposes as non-profit or public benefit corporations, rather than as governmental hospitals. Examples include the Truman Medical Center, of Kansas City, Missouri; the Pacific Medical Center, of Seattle, Washington (formerly a Federal Public Health Service Hospital); the Regional Medical Center of St. Louis (formerly St. Louis City and County Hospitals); the Regional Medical Center at Memphis (formerly Memphis City Hospital) and the New York City Health and Hospitals Corporation. Notwithstanding their corporate structure, these entities operate in every respect as public hospitals, and the locality they serve (state, city, county) generally maintains considerable control (e.g., appoints members to the hospital board, reviews its budget, and often provides a significant share of the funding for the hospital -- 35% of the total budget on average for members of NAPH).

In defining a governmental unit, the Ways and Means Committee Report language accompanying H.R.3838 states in part that, "State owned and operated universities are governmental entities." H. Rept. No. 99-426, 99th Cong., 1st Sess., 519. A footnote accompanying this statement provides:

"The Committee is aware that certain State universitites also have received determination letters regarding their tax-exempt status under Code section 501(c)(3). The Committee intends that, to the extent of a State-owned and -operated university's activities as a governmental unit, bonds for the State university will be treated as governmental bonds rather than as non-essential function bonds for activities of a section 501(c)(3) organization." Id.

It is important to clarify that the activities of a public hospital are similarly to be treated as the activities of a governmental unit even if the organization is formally structured as a Section 501(c)(3) hospital, such as a public benefit corporation. Thus, the activities of a public hospital would not be a trade or business either for purposes of determining the percentage of the proceeds of an issue which are used in a trade or business or of determing the percentage of the issue which is secured by revenues from a trade or business.

In addition, public hospitals often share physician services or other resources by contracting for such services or other resources with other public or private organizations (e.g., medical schools). We believe that the furnishing of services to a public hospital should not be treated as the trade or business of the organization furnishing the services, but rather should be treated as the provision of direct governmental hospital services.

b. Early Issuance/5% Rule

H.R. 3838 requires that five percent of the proceeds of a bond issue must be spent for the exempt purpose within 30 days of the issuance of the bonds. We are concerned that this requirement is unnecessarily burdensome on many governmental issuers and may prevent some localities from engaging in any public financing due to additional local law restrictions on public projects. NAPH strongly urges the Committee to eliminate this restriction and retain present law.

c. Expenditure of Proceeds/3 Year Rule

In addition, H.R. 3838 requires that all bond proceeds (other than reasonably required reserve or replacement funds) be spent for the exempt purpose within three years after the date of issuance. Like the 30-day requirement, this arbitrary and inflexible rule will create serious obstacles for projects whenever ambitious schedules cannot be adhered to or unforeseen difficulties arise. In some cases, public hospitals are required by local laws or practice to adopt construction periods of longer than three years. NAPH believes that this three year requirement should also be eliminated or amended, either generally or for governmental hospitals in particular, to take into account this need for greater flexibility.

d. Restricting the Trade or Business Use of Governmental Bonds

Finally, H.R. 3838 would subject any portion of an essential function bond which is used by (or loaned to) a private business to the Statewide volume limitations, thus penalizing governmental entities which join with private business in activities benefitting the public. NAPH proposes that you eliminate the inclusion of any governmental bond proceeds under the Statewide volume caps applicable to quasi-governmental bonds.

2. Access to Capital for Public Hospitals

In addition to our specific concerns about H.R. 3838, we also have more general concerns about the future ability of essential providers of care to the poor to obtain access to capital. We hope we can count upon the members of this Committee to assist us to address both our short-range and long-range needs with regard to this issue.

a. Mortgage Insurance Under § 242 Of The National Housing Act

Three years ago, Congress adopted a bipartisan amendment to the 1983 Housing Act to make mortgage insurance under the FHA Section 242 program available to public hospitals, providing capital which is badly needed for renovations and construction by some of our nation's most essential providers of health care. Despite legislative action in 1983, 1984, and numerous letters and discussions, final regulations have not issued, and public hospitals which could proceed under existing regulations have not been permitted to do so.

In Section 104(f) of the Housing and Community Development Technical Amendments of 1984, Congress commanded that "the Secretary of Housing and Urban Development shall, not later than October 31, 1984, issue regulations to carry out the amendments made to Section 242..." As explained more painstakingly in the Statement of Managers of the Technical Amendments Conference Report (No. 98-1103 at 24):

> "To assure this insurance program is promptly implemented, the conferees direct the Secretary of Health and Human Services (HHS) to immediately begin accepting and processing applications from public hospitals for mortgage insurance with the expectation that regulations will be in effect by the time a final commitment is required." (Emphasis added.)

A notice of proposed rulemaking ("NPRM") at 49 Fed. Reg. 40,047 (October 12, 1984), made technical amendments to incorporate public hospitals into the current regulatory scheme. The comment period closed December 11, 1984. However, no final regulations have ever been issued. If regulations to bring public hospitals into the Section 242 program are not finalized soon, qualified public hospitals will not be able to obtain the mortgage insurance Congress intended to make available to them until 1987 -- four years after Congress directed that the program be expanded to insure public hospitals.

NAPH has proposed addition legislation that would require HUD to implement this bipartisan 1983 amendment -- through issuance of final regulations -- by a date certain. If regulations do not issue by such date, applications should then be processed, and insurance commitments issued, under existing regulations for non-public facilities. DHHS, which actually administers this program for HUD, believes it could process public hospital applications under current regulations. We therefore ask the members of this committee to support us in this legislative and regulatory effort as well.

2. Need For Future Institutional Support

Finally, we agree with those who maintain that it is not necessarily the role of the Medicare program to solve problems of equity and access to care for the non-Medicare poor. We do believe that Congress must ensure that "reforms" in Medicare and other current programs not unnecessarily or unintentionally damage or further erode the tenuous situation of hospitals providing such care. However, ultimately, access must be a responsibility assumed directly by governments at all levels -- including the federal level. In that regard, we hope that this committee will also work with us in the future to resolve our more basic needs. Public hospitals are an important part of America's urban infrastructure. With no sign of universal national health coverage on the immediate horizon, we must presume they will remain so. Given the substantial other changes that are occuring in our nation's health system today, we hope you will work with us on more direct programs to assist in the preservation of at least the core of that infrastructure.

SUMMARY OF THE STATEMENT

FOR THE RECORD SUBMITTED BY

THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

ON PAYMENT OF CAPITAL COSTS UNDER MEDICARE

1. NARF is the principal national membership organization of to medical and vocational community based rehabilitation facilities. Its members include most of the freestanding rehabilitation hospitals and rehabilitation units, general hospitals and comprehensive outpatient rehabilitation facilities in the country.
2. NARF understand from conversations with the Department of Health and Human Services that it has a policy allowing it to change the method of payment for capital costs under medicare for rehabilitation hospitals and units and for other providers excluded from the medicare prospective payment system by regulation at the same time it proposes to change payment for these costs for hospitals included in the PPS.
3. The goal of rehabilitation is to work with the patient to restore his or her maximum functional capacity. Rehabilitation is becoming of increasing significance to the population covered by the medicare program because of the high incidence of certain disabling conditions among older people.
4. The nature of services provided in rehabilitation hospitals and units makes them very different in their operating characteristics. Their average length of stay is four or five times greater than that in acute care hospitals (34 days vs. 7.6 days.) Over 50% of their patients are medicare beneficiaries. The longer length of stay result in different capital:discharge ratios. Any change in payments

for capital costs will have a greater impact in this class of provider.

5. Therefore we urge that the Subcommittee in considering reforming payment for capital expenses under medicare for rehabilitation facilities:

a) Draft legislation prohibiting the Secretary from implementing any new payment methodology with respect to capital related costs of exempt and PPS providers at any time prior to Congress enacting legislation which specifically directs the Secretary to implement a new payment methodology for such cost. Such legislation should also require that the regulations currently in effect for capital payment remain in effect until a change is made;

b) Not consider altering a payment methodology for capital cost for excluded providers until all the studies on exempt rehabilitation hospitals and units are completed and a different form(s) of a prospective payment system for exempt entities other than the target ceiling limitation is considered; and

c) When change in payment for the capital costs of exempt rehabilitation hospitals and units are considered any such coverage should take into account the longer length of stay of these institutions; distinguish between previously invested and new capital; rely on cost data from rehabilitation facilities; and allow for depreciation of undepreciated captital costs during the transition period.

STATEMENT SUBMITTED BY THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES TO THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON FINANCE

This statement is submitted by the National Association of Rehabilitation Facilities to the Subcommittee on Health in connection with the Subcommittee's consideration of proposals to include capital costs in the Medicare prospective payment system. Our statement is addressed to the proposal advanced by the Reagan Administration, as outlined in the statement of Robert Helms, Acting Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services on February 24, 1986, and particularly to how the Administration's proposal may or may not bear on rehabilitation hospitals and rehabilitation units in general hospitals excluded from the medicare prospective payment system.

NARF is the principal national membership organization of medical and vocational rehabilitation facilities. Most of the freestanding rehabilitation hospitals in the country and a good number of the rehabilitation units are our members. We wish to call the attention of the Subcommittee to the unique characteristics of these facilities and the special consideration that must be given to these characteristics in fashioning legislation to deal with Medicare payment for capital costs.

Mr. Helms stated in his testimony that the Administration believes it has the authority under Section 1886 (a) (4) to change the payment methodology for capital payments under Medicare by regulation. While his entire testimony speaks only of hospitals under the PPS, we understand from conversations with the Department that it has a policy allowing it to change capital payments for Medicare excluded hospitals and units by regulation as well. The exact mechanics of such a proposal have not been developed. We do not believe that the Administration has the

authority to make such changes by regulation. Furthermore, changes made by the regulation would not result in any significant budgetary savings, but would prove highly disruptive to the excluded facilities. We recommend that Congress enact legislation prohibiting the Secretary from promulgating any regulations pursuant to the Social Security Act which would effect or change payment for capital expenses under Medicare.

First, it may be helpful to describe the nature of these facilities and the services they provide. Rehabilitation is addressed to restoration of function for people whose capacities are impaired by injury, disease or congenital defects. Rehabilitation is a fairly recent addition to the health care system having developed largely since World War II. Through a combination of coordinated therapies, rehabilitation seeks to assist patients to gain or regain optimum levels of function in movement, cognitive capacity and other areas. Unlike most acute services that are focused on treating a patient by doing things to him or her, rehabilitation is concerned with helping to improve the patient's ability to function by working with the patient. The individual services that are generally included in a coordinated program of rehabilitation are physical, occupational, and speech therapy, prosthetics and orthotics, audiology and additional supporting therapies.

Rehabilitation is becoming of increasing significance to the population covered by the Medicare program, because of the high incidence of certain disabling conditions among older people, particularly stroke. Stroke patients constitute far and away the largest group of Medicare patients seen in inpatient rehabilitation facilities.

The nature of the services provided by rehabilitation hospitals and units makes them very different in their operating characteristics. NARF recently completed a study of the industry and its characteristics. We found, as anticipated, that lengths

of stay are substantially longer than in acute care hospitals, by a factor of four or greater depending on the patient's condition. The average length of stay is over 34 days for all patients. In some facilities specializing in such severe problems such as spinal cord injury, the length of stay is considerably longer, as high as 90 days or more. The current length of stay for PPS hospitals is about 7.6 days.

When the Medicare PPS system was implemented the unique characteristics of rehabilitation facilities were recognized. It was also recognized that the data from which DRGs were constructed did not include information on rehabilitation facilities and cases. Consequently, rehabilitation hospitals and units were excluded from the system and continue to be paid by Medicare on a reasonable cost basis. Under Medicare, rehabilitation hospitals and units are excluded from the PPS if they meet certain tests including having 75 percent of their patients require intensive rehabilitation services for any of the following diagnostic conditions:

(a) Stroke

(b) Spinal cord injury

(c) Congenital deformity

(d) Amputation

(e) Major multiple trauma

(f) Fracture of femur (hip fracture)

(g) Brain injury

(h) Polyarthritis, including rheumatoid arthritis

(i) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease

(j) Burns

Currently there are 71 rehabilitation hospitals and 436 rehabilitation units excluded from the Medicare prospective payment system. These facilities represent approximately 17,000

excluded beds. This equates to .008 bed per 100,000 population and .0005 beds per Medicare beneficiary.

All of the foregoing is in way of a preface to addressing the peculiar position of rehabilitation hospitals and units in the application of a change in the method of paying for capital costs of a prospective payment by Medicare.

First, many of the observations made to the Subcommittee by other witnesses are valid for rehabilitation. The Administration's proposal for a very quick phase-in of a prospective payment system for capital costs fails to take into consideration the disparate circumstances of hospitals with respect to their capital costs. Such costs vary widely, depending on the age of the facilities and equipment and their mode and cost of financing. Certainly with the considerable fluctuations in interest rates in recent years, hospitals with the same operating characterisitics, occupancy rates and level of efficiency can have very different outlays for their physical plants and equipment. Capital cost is not just an accounting entry for depreciation. It is also dollars to bond holders and other lenders.

The Administration's position seems to be that any hospital that undertook a capital investment relying on the cost reimbursement system of Medicare was imprudent and is fair game for an abrupt change in the rules. When capital projects are financed over 20 and 30 year periods, this is not a realistic position. It is particularly ironic when one recognizes that Medicare has by regulation forced hospitals to depreciate capital costs over very long periods as a means of reducing Medicare outlays. One way to harmonize these disparate attitudes would be to provide for the depreciation of all undepreciated capital costs incurred prior to the change in the system over the transition period. If this principle is adopted then the term of the transition period becomes less significant; although were it

adopted the merits of a longer transition period would gain considerable appeal for the Administration.

The treatment of previously invested capital by Medicare is of particular concern to rehabilitation hospitals and units because they serve a substantial number of Medicare patients. Clearly, the greater the percentage of Medicare patients, the greater the impact of a change in Medicare treatment of capital cost. Rehabilitation hospitals and units average slightly over 50 percent Medicare patients because of the high incidence of stroke, arthritis and similar conditions among Medicare beneficiaries.

To cushion the impact of such a change on hospitals with exposure to a radical change in government policy, we suggest that a distinction be drawn between previously invested capital and new capital with proper demarcation to account for work in progress. Prior capital and interest expense associated with it should be reduced to current value and depreciated over whatever transition period is selected. New capital can be covered in a transition formula based on replacement cost of the number of beds deemed necessary for inpatient service -- including recognition of specialty services. By such a mechanism the Congress will keep faith with those who have relyed on a system sanctioned by federal law for over 20 years.

Whatever transition mechanism is selected, we urge the Subcommittee to recognize that if a capital factor is to be paid on a prospective per-discharge basis, provision must be made for rehabilitation hospitals and units because of their longer lengths of stay and, therefore, very different capital:discharge ratios. As noted above, lengths of stay in rehabilitation hospitals and units are four to five times longer than in acute facilities. Any per-incident capital cost calculated from acute care data and applied to rehabilitation facilities must be adjusted to reflect this difference. Either a capital cost

calculation should be made from cost reports for rehabilitation facilities, or any figure generally derived from general hospitals should be increased by a factor representing the relative lengths of stay of the two types of facilities.

One other feature of the Administration's proposal that deserves comment is the proposal to deduct from Medicare capital payments, however calculated, interest earned by providers on funded depreciation accounts. This concept is wrong. It reflects an intent only to cut federal outlays rather than to deal fairly with the issue. Funded depreciation accounts are for replacement of capital items. Amounts received in depreciation allowances are in repayment of capital spent in the past when, in all recent memory, money had greater purchasing power. Thus, depreciation alone never is equal to replacement cost. Confiscation of earnings on funded depreciation accounts guarantees that hospitals can not accrue, through funded depreciation, the replacement costs of assets being depreciated. The Administration's proposal on this point is fundamentally flawed and should be rejected.

Therefore we urge that the Subcommittee in considering reforming payment for capital expenses under medicare for rehabilitation facilities:

1) draft legislation prohibiting the Secretary from implementing any new payment methodology with respect to capital related costs of exempt and PPS providers at any time prior to Congress enacting legislation which specifically directs the Secretary to implement a new payment methodology for such cost. Such legislation should also require that the regulations currently in effect for capital payment remain in effect until a change is made;

2) Not consider altering a payment methodology for capital cost for excluded providers until all the studies on

exempt hospitals and units are completed and different form(s) of a prospective payment system for exempt entities other than the target ceiling limitation is considered; and

3) When a change in payment for the capital costs of exempt rehabilitation hospitals and units is considered any such change should take into account the longer length of stay of these institutions; distinguish between previously invested and new capital; rely on cost data from rehabilitation facilities; and allow for depreciation of undepreciated capital costs during the transition period.

We would be pleased to discuss these points with you.

We hope the Subcommittee will be congnizant of these considerations. A capital plan that fails to deal adequately and fairley with the return and cost of capital will have serious adverse effects on both rehabilitation hospitals and patients.

John A. Doyle
Executive Director

STATEMENT OF THE NATIONAL COMMITTEE FOR QUALITY HEALTH CARE

Introduction

The National Committee for Quality Health Care respectively submits the following comments to the Ways and Means Health Subcommittee in its deliberations on the critical issue of payment for capital under the Medicare program. The National Committee for Quality Health Care is a coalition, of health care companies including hospital providers, nursing homes, HMO's, manufacturers and professional firms which provide products and services to the health care industry. Our goal is to promote public policies which impact both access to and the quality of our medical care system. There is no more important issue relating to these objectives than that of adequate capital payment to hospitals and other providers. Without adequate capital payment, the quality of our nation's health care facilities will erode and technological innovation will be stymied.

Congressional Intent

In 1983 the Congress made clear its intention that capital payments under Medicare be incorporated into the prospective payment system for operating costs. The Department of Health and Human Services was directed to study this issue and make recommendations to Congress so that Congress could legislate a change in capital policy by October 1, 1986. The Administration has yet to produce a report but has formulated a proposal which it intends to promulgate as a regulation. The Administration's authority to execute a new capital policy without Congressional approval is highly questionable. The National Committee strongly urges that Congress legislatively prohibit the Administration from implementing any change in

capital policy until Congress decides on a fair and equitable capital payment method.

Administration Proposal

Although the details of the Administration's capital proposal have yet to be published, the method by which capital would be paid over a three-year effective transition, would fall far short of either meeting past capital commitments of hospitals or satisfying future capital needs of health care institutions in this country. In fact by fiscal year 1991, the Administration's proposal would reduce current law commitments by nearly one-half. Such a drastic reduction in payment would have a devastating impact on hospitals and the level of care they provide. The following is a list of shortcomings in the proposal and its methodology:

- Using FY 1983 as the base year for the national rate does not come close to approximating the current actual Medicare capital commitments of hospitals.

- Reducing the capital base by return on equity and interest earned on funded depreciation is an unfair retroactive change in rules governing capital reimbursement.

- Using fiscal year 1986 for the hospital-specific rate penalizes institutions who may have made capital commitments as much as three years earlier and whose costs will not be reflected in their 1986 cost reports.

- The proposed capital update factors do not reflect actual Medicare growth in capital outlays projected by the DHHS actuaries'.
- The transition period is totally inadequate to allow reasonable time for hospitals to adjust to the new payment scheme.

In short, the Administration's proposal fails to recognize both past capital commitments by hospitals and their future capital needs. The National Committee strenuously opposes its implementation.

Dispelling Some Capital Myths

There have been many misconceptions about the amount and use of capital by hospitals. A popular belief is that hospitals in a cost reimbursed world have wontonly and flagrantly spent capital dollars on new plant and equipment. However until recently, the amount of capital as a percent of operating costs has remained fairly constant. Hospitals have followed normal investment cycles to replace obsolete and outdated facilities and equipment and to keep pace with rapidly evolving technologies. Another misconception is that hospitals continue to build unnecessary inpatient beds. Most of the recent capital investment has been in direct response to the new payment incentives initiated by Medicare and the private purchasers of care. Recent data suggests new capital funding is not going to support development of new beds or unnecessary facilities, but to modernize existing facilities or shift care into more appropriate settings. Hospitals are moving their resources into more efficient and effective methods of health care delivery including outpatient services, ambulatory surgery, home health care, patient education, etc.

As hospitals progress toward more integrated systems of health care delivery, they are developing risk sharing arrangements and joint ventures with physicians and other providers which also require substantial amounts of capital.

The National Committee views these dynamic changes in our health care system as a positive force driving the medical system to a lower cost, higher quality system. To arbitrarily reduce access to capital funds or to deny full payment for existing commitments would seriously hinder these beneficial changes.

Finally, there is a persistent belief by some that limiting capital expenditures through government sponsored review is the best way to control scarce resources. The National Committee believes otherwise, the capital markets for both equity and bond financing are effective mechanisms for assuring that capital is invested for necessary projects in viable institutions. The increased competition for capital among various segments of our economy may leave hospitals high and dry in the quest for vital financial life blood. Abrupt changes in Medicare capital payments combined with substantially reduced operating payment levels would threaten most hospitals' ability to obtain capital in these markets under any scenario. This is especially true with the proposed changes passed by the House and now under consideration in the Senate regarding the availability of tax exempt bonds. The state volume limitations which apply to 501(c)(3) organizations and particularly hospitals will have a chilling effect on the availability of new capital funds in the future. Therefore, the prospect of uncontrollable and unnecessary new capital investment in the current environment is highly improbable.

Principles for Capital

The National Committee believes that the following principles should be maintained in any new capital payment methodology: First, capital should ultimately become part of an all-inclusive rate which includes DRG operating payments. Second, recognizes hospital-specific capital costs obligated prior to the implementation of a new payment system should be protected. Third, Medicare capital should not be redefined or retroactively adjusted. Fourth, capital should be updated to reflect current growth in Medicare capital costs. Fifth, a long transition period should be allowed for hospitals to gradually adjust to the national rate. Sixth, section 1122 authority and federal planning laws should be eliminated.

There are many potential methodologies that satisfy these basic principles. The National Committee does not endorse any specific proposal in this regard. However, one approach could be to distinguish between old (previously committed) capital expenditures and new capital expenditures incurred after date of enactment or implementation. Old capital would be paid on a reasonable cost basis and grandfathered into the new system while new capital could be paid at an average rate updated by a capital growth factor. If a transition is desired, old and new capital could be blended together with each hospital gradually moving with an average payment rate at their own management discretion. Such a system would avoid having to select a specified transition period. Moreover, institutions with high capital costs would not be penalized for either having made investments nor would windfalls benefit to low capital hospitals. This approach is consistent with the manner in which Congress has treated many other government programs when changing from one system to another.

Capital Redistribution

The National Committee believes that payment methods which result in a redistribution of capital from high capital institutions to low capital institutions is both unfair and unwise public policy. Unlike operating costs where management can adjust to new payment levels, within a relatively short period of time, fixed capital costs with long term obligations do not provide management flexibility to reduce commitments or absorb payment reductions. It is inequitable to shift payments from institutions with current commitments to those who have not yet incurred such commitments. Moreover, excessive payments to some institutions might encourage unnecessary capital investment or use of capital for subsidizing operations. The government's capital policy should not be used to prop up inefficient institutions at the expense of other more efficient hospitals. Low capital hospitals should receive adequate reimbursement for new capital expenditures rather than windfall payments for expenditures they have not made.

Summary

The Medicare capital payment issue is one of vital interest to all segments of the health care system. The capital question is a complex one which deserves Congress' full deliberation. The Administration should not be allowed to usurp Congressional authority by regulating this matter. The National Committee recommends Congress move at once to prevent the Administration from taking regulatory action without legislative guidance. Further, the National Committee recommends the Ways and Means Health Subcommittee seriously consider a methodology which distinguishes between old capital and new capital investment and provide adequate funding for both.

The Medicare program through its capital policy has enabled providers to serve Medicare beneficiaries in a quality manner. Abrupt and unreasonable changes in capital policy will have devastating consequences for hospitals and their patients in the short term. Over the longer term it will erode the capital stock of our nation's health care institutions and stifle technological innovation necessary to achieve the cost efficiency with high quality we all want. The National Committee for Quality Health Care appreciates this opportunity to share our views for the record.

STATEMENT OF THE

NATIONAL ELECTRICAL MANUFACTURERS ASSOCIATION

The National Electrical Manufacturers Association* appreciates the opportunity to present its views to the Subcommittee on Health of the Ways and Means Committee of the U.S. House of Representatives on proposals for incorporating capital costs into the Medicare prospective payment system (pps).

NEMA is encouraged by the evidence of the Subcommittee's interest to consider the matter earnestly and look at all sides of the issue. We hope that our remarks, representing the concerns of manufacturers of medical capital equipment, will be helpful to the Subcommittee by providing another viewpoint for their consideration.

Initially, we are encouraged by Senator Durenberger's proposal, S.2121, the Fair Deal Capital Payment Act. This proposal most evidences the concern of all parties that any proposal is adequate in amount and fair in its implementation. Nothing short of S.2121 would adequately compensate hospitals and ensure that quality of care will not be adversely affected. In contrast, the Administration's proposed regulation ignores hospitals' needs and will inevitably adversely impact quality care.

Further, NEMA strongly urges the Subcommittee to discount the recommendation of the Prospective Payment Assessment Commission (ProPac) that moveable equipment capital be treated not only differently from other capital but also differently from any other Medicare coverage. Without any articulated rationale, ProPac recommended that moveables be incorporated immediately

* NEMA is the principal trade association of the elctrical manufacturing industry. The Association has some 570 member manufacturing companies which are affiliated with one or more of its product Divisions, each Division representing in essence a separate and distinct industry. The electrical products within NEMA's scope are used either as components or as end-equipment in all major phases of the generation, transmission, distribution, control and utilization of electrical energy.

into pps, without any transition period. Obviously a decision to purchase some capital equipment involves a long-term commitment just as any other capital and eliminating a transition period would undoubtedly penalize hospitals who have recently made large purchases. The administrative complexity it would entail does not justify making the distinction. For example, how can the costs involved with the installation of a magnetic resonance imaging machine, which requires extensive plant renovation for housing the equipment, be separated into fixed and moveable costs.

We question the justification for singling out moveable equipment when operating costs were incorporated into pps with a transition period and plant equipment is proposed to be so also. Ignoring the vital contribution that this equipment makes to high quality care is ignoring an integral ingredient necessary to quality care. Not only can high technology capital equipment be credited with saving many lives and substantially improving the lives of many others, but it also can produce long-term costs savings in affecting early detection of some diseases, thereby facilitating early discharges.

NEMA would also like to reiterate its concern as expressed in its comments to the Senate Finance Health Subcommittee in November that the data used to project costs should realistically reflect actual costs and that it is not skewed by uncertainty in the marketplace because of the implementation of pps. We, therefore, suggested that a more accurate projection would include pre-pps years and be based on an average of a few years, possibly 1980-83.

We would also like to reiterate our suggestion that any proposal that is finally implemented be monitored carefully by Congress to assess its effectiveness. Because the proposal must be based on imcomplete data and because the entire prospective payment system has not been implemented as smoothly as was anticipated, this monitoring will be a necessary safeguard.

Testimony

of

John E. Callender
Senior Vice President
Ohio Hospital Association

In 1983, as part of the legislative effort to stabilize the financial condition of the Social Security Cash Benefit Programs, Congress also adopted a Medicare DRG prospective payment system for inpatient hospital operating costs. Prior to the adoption of this DRG prospective payment formula, hospitals were reimbursed for their inpatient operating costs on the basis of reasonable and allowable costs.

During the limited debate on the adoption of this DRG prospective payment formula, the Congress quickly realized that the DRG system alone could not adequately reimburse hospitals for certain reasonable and allowable costs: e.g., capital and medical education costs. The Social Security Amendments of 1983 specifically excluded capital costs from the Medicare DRG prospective payment formula until October 1, 1986.

The above date was selected because of concern by Congress that the DRG prospective payment formula should, to the maximum extent possible, include all costs of care, but the Congress realized the complexities associated with the incorporation of capital costs into the prospective payment formula.

Section 603 of the Social Security Amendments of 1983 required the Secretary of Health & Human Services:

> "study, develop and report to Congress within 18 months after the date of enactment of this Act on the method and proposals for legislation by which capital related costs...can be included within the prospective payment amounts...".

If the Secretary had complied with the requirements of Section 603 of the Social Security Amendments of 1983, the Congress and the health care industry would have had in excess of one full year to study the secretary's report and arrive at an acceptable legislative compromise. To date, the Secretary has not issued a report or recommendation as required by Section 603 of the Act, even though the date for issuance of the report was October 20, 1984.

The Ohio Hospital Association supports the concept of the incorporation of capital costs into the Medicare DRG prospective payment formula. We believe that for any payment formula to be truly prospective and cost efficient it should not distinguish between the type of costs incurred to produce a given unit of service. The inclusion of capital costs into the Medicare DRG prospective payment formula presents several issues which must be resolved in order for the formula to be fair and equitable to hospitals and assure that the Medicare beneficiary will have continued access to high quality health care services.

The Ohio Hospital Association supports the proposal offered by the American Hospital Association for the inclusion of capital costs into the Medicare DRG prospective payment system. The "consolidation price approach" formula offered by AHA recognizes the different capital cost structures which exist amongst this nation's hospitals, provides for a phase-in period of sufficient duration to allow hospitals to adjust to the new formula, provides the capital markets with sufficient assurance that an efficiently managed hospital will be able to repay its debt, and will allow an efficiently managed hospital to accumulate working capital in order to meet its future capital needs.

While the Ohio Hospital Association supports the concept of incorporating capital costs into the prospective payment system, we cannot support the current effort by the Secretary of Health & Human Services to adopt a capital cost formula via regulations. The regulatory approach currently endorsed by the Secretary is designed as a budget cutting tool and is not a good faith effort to place the issue before Congress for debate and resolution. In addition, a regulatory approach does not resolve the apparent conflict with Section 601(g)(1) of the Social Security Amendments of 1983. That section clearly requires that Congress enact a formula for incorporating capital costs into the Medicare DRG formula or capital costs obligated by hospitals on or after September 30, 1986 must have been approved under a Section 1122 Review Program.

This conflict between regulation, law and the restrictions placed on the issuance of Tax Exempt Debt by hospitals via the Tax Reform Act of 1985 could seriously disrupt the delivery of hospitals' services to the nation's Medicare beneficiaries. A Section 1122 Review Program would be an additional administrative burden on the hospital industry which cannot be justified in light of the increasing emphasis on competition as the means to control health care expenditures. Section 1122 Review has outlived its usefulness and should be eliminated.

UNIVERSITY HOSPITAL
at Boston University Medical Center

ANALYSIS OF PROPOSALS TO MODIFY MEDICARE CAPITAL REIMBURSEMENT MECHANISMS

Prepared for Hearing
of
Subcommittee on Health, Committee on Ways and Means
U.S. House of Representatives
February 24, 1986

EXECUTIVE SUMMARY

This paper is University Hospital's analysis of three proposals to incorporate capital costs into Medicare's Prospective Payment System. These proposals should be substantially modified because their implementation would cause significant financial hardship for many efficiently run hospitals--especially tertiary teaching hospitals--and will cause difficulty for many hospitals in meeting obligations to bondholders.

To project the effects of these proposals, University Hospital ("UH") has analyzed its own financial data and comparable information for five additional major Boston tertiary teaching hospitals[1]. These hospitals represent a national, regional and state center of superior medical service, education, training and research, serving as the principal teaching hospitals of Boston University School of Medicine, Harvard Medical School and Tufts University School of Medicine. They also provide employment to more than 26,000 people, representing a payroll of over $500 million annually.

The implementation of proposed capital payments under or incorporated into Medicare's Prospective Payment System will have a deleterious effect on the group of hospitals studied, despite their high average occupancy rate of 84 percent. Based on the least onerous of the three current proposals (proposed in a working paper circulated by the Department of Health and Human Services), University Hospital's analysis shows that the six hospitals would experience an aggregate $4.7 million reduction in Medicare reimbursement in an average year during the proposed seven-year phase-in period. After the system is fully implemented, the aggregate annual loss for the six hospitals would be $14 million. (University Hospital would lose $1.6 million annually during the transition and $4 million annually thereafter.)

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1 Hospitals that were studied are the following: Beth Israel Hospital, Brigham and Women's Hospital, Massachusetts General Hospital, New England Deaconess Hospital, New England Medical Center Hospitals and University Hospital.

University Hospital has identified specific problems that are common to all three proposals and are responsible for these significant losses:

1. Tertiary Teaching Hospitals: By limiting capital reimbursement to average costs, the proposals fail to recognize the above-average capital costs inherent in the high-intensity patient care, state-of-the-art technology and medical-training functions of the tertiary teaching hospitals. Use of the average may undermine the superior quality of care, the advancement of medical science and the preparation of future generations of health professionals that take place at these institutions.

2. Transition Period: Because hospital bond commitments are generally far longer than the proposed phase-in periods, many hospitals will not be able to reduce their major capital costs to adjust to the new reimbursement system. Particularly affected will be hospitals with recent capital investments (i.e., those institutions with "younger capital"). By using average capital costs, the proposals cause losses to hospitals with newer facilities (and therefore higher capital costs). Hence, even if a hospital is efficient and maintains high occupancy rates it may be unable to respond to the new system's demands. This may cause some hospitals to be unable to meet their obligations to bondholders.

In response to these concerns, UH recommends that Congress develop a prospective payment plan that provides:

1. An adjustment to compensate teaching hospitals for their additional capital costs. We recommend an increase in the capital payment of 1 to 2 percent for teaching hospitals.

2. A realistic transition. Hospitals must be allowed a sufficient time to adjust their capital costs to respond to the new system of capital reimbursement. In particular, hospitals with younger capital should not be put in a situation to which they cannot respond. Two alternative approaches are recommended, which may be applied independently or in tandem:

   a. Medicare capital payments should be indexed to an individual hospital's currently existing level of outstanding fixed debt, contingent upon maintenance of high occupancy rates. The intent of this approach is to have any disincentives in the reimbursement system target inefficient providers rather than those institutions with younger assets.

   b. The length of the transition period should be extended for those hospitals with substantial debt financing. The intent of this alternative is to have the phase-in period bear a realistic relationship to the length of fixed bond commitments.

I. INTRODUCTION

In preparation for this hearing of the Subcommittee on Health, Committee on Ways and Means, staff of University Hospital at Boston University Medical Center analyzed the effects of three proposals that have been discussed to incorporate capital costs into Medicare's Prospective Payment System. The analysis examined the effects such proposals would have on Boston's six key nonspecialized tertiary teaching hospitals: Beth Israel Hospital, Brigham & Women's Hospital, Massachusetts General Hospital, New England Deaconess Hospital, New England Medical Center Hospitals and University Hospital itself. These six voluntary, not-for-profit hospitals have an aggregate complement of nearly 3,600 beds and annual operating expenses totaling more than $1 billion; in 1985 they served over 124,000 inpatients while maintaining inpatient occupancy levels averaging 84 percent. These six hospitals provide employment to more than 26,000 people with a resulting payroll of more than $500 million annually.

For the year ended September 30, 1985, these institutions had total revenues of $1.145 billion, with an operating income of $10.5 million. This represents an operating margin of only 0.9 percent, in comparison to a national operating margin of 2.6 percent. Despite the large size of these institutions, their profitability margin is very narrow and extremely vulnerable to changes in the reimbursement mechanisms that affect them.

The six hospitals that were studied provide acute-care services and serve as tertiary referral centers for a wide range of the city, state and national communities. They are the major teaching hospitals for the medical schools of Boston University, Harvard University and Tufts University, offering extensive educational services to medical students, resident physicians, and established practitioners. Each conducts a sizeable sponsored-research program responsible for advances in diagnosis and therapy that are of international renown and major human and economic significance. Collectively and individually, these hospitals have a nearly 200-year heritage of consistent excellence in patient care, in the education and training of health professionals, and in medical research.[2]

These six Boston teaching hospitals have made a significant investment in their facilities for providing patient care. On September 30, 1985, their property, plant and equipment totaled $1.066 billion, with accumulated depreciation of $320 million. This fixed-asset investment was financed through equity bonds and through debt. On September 30, 1985, these six hospitals alone had remaining debt obligations of $468 million. The debt, which consists primarily of tax-exempt revenue bonds, was incurred with the expectation that the reimbursement system would provide the cash flow to meet the required repayment of the bondholders.

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2 Exhibit 1 is a profile of Six Boston Teaching Hospitals, prepared in 1983 by Coopers & Lybrand. Five of the hospitals studied in this analysis were participants in the 1983 profile.

II. THE PROPOSED MECHANISMS

Three mechanisms have been proposed to incorporate capital costs into the Prospective Payment System. The first is a draft report to Congress prepared by the U.S. Department of Health and Human Services (HHS) in October, 1985.[3] The second is included in the Administration budget for FY 1987. The third proposal, S. 1559, is sponsored by Senators David Durenberger (R.-Minn.), chairman of the Health Subcommittee of the Senate Finance Committee, and Daniel Quayle (R.-Ind.). Sen. Durenberger intends to introduce a revised capital payment plan with a longer transition period than that proposed in S. 1559. In general these proposals share these common objectives:

- To create incentives for hospitals to engage in efficient, business-like capital spending programs.
- To create a uniform PPS rate for ease of administration and to eliminate perverse incentives contained in a dual payment system.
- To adequately reimburse hospitals so as to ensure high quality care for Medicare patients.
- To provide a transition period allowing hospitals time to adjust their capital costs to meet the new environment.

To implement these goals, HSS proposed in its draft report to Congress a uniform national PPS rate beginning in Fiscal Year 1994. The capital portion of the rate would be based on national average capital costs per discharge. The transition to this national average rate would begin in Fiscal Year 1987 through a seven-year phase-in; in each year between 1987 and 1994, a hospital's capital reimbursement will be based in decreasing proportions on the hospital's own costs:

YEAR	HOSPITAL-SPECIFIC PROPORTION	NATIONAL AVERAGE PROPORTION
1987	95%	5%
1988	90%	10%
1989	80%	20%
1990	65%	35%
1991	50%	50%
1992	30%	70%
1993	10%	90%
1994	0%	100% (Full Implementation)

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3 Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, Hospital Capital Expenses: A Medicare Payment Strategy for the Future, October, 1985.

The Durenberger/Quayle plan, S. 1559, would incorporate capital as a uniform add-on to payments over a five-year transition period, as shown below.

YEAR	HOSPITAL-SPECIFIC PROPORTION	NATIONAL AVERAGE PROPORTION
1987	95%	5%
1988	85%	15%
1989	70%	30%
1990	50%	50%
1991	20%	80%
1992	0%	100% (Full Implementation)

Sen. Durenberger's announced intention is to file a revised bill, which will reportedly be similar to the HSS recommendations but will provide for a longer phase-in period.

At the budget briefing conducted on February 5, 1986, HHS Secretary Otis Bowen, M.D., emphasized that Medicare payments for capital costs would be phased into the Prospective Payment System over the next four years. The Administration plan, which will be issued as a proposed regulation in early June, is projected to reduce budget outlays $456 million in Fiscal Year 1987 and $4.2 billion over three years.

When this new system is fully implemented in 1991, each PPS hospital would be paid a fixed, all-inclusive rate that includes both capital and operating costs for each Medicare admission. The capital portion would be added to the current operating standardized amounts and multiplied by the appropriate DRG weight to produce a total payment per case.

There will be a four-year transition period with the payment amounts being composed of a blend of a hospital-specific cost-based portion and a federal part based on a national average. For FY 1987, the blend would be 80 percent hospital-specific and 20 percent federal; by Fiscal Year 1991, the rate would be 100 percent federal.

III. IMPACT

Implementation of any of the above proposals will cause serious reimbursement losses to University Hospital and to the community of Boston's tertiary teaching hospitals. Based on preliminary analysis, University Hospital concludes that even the least onerous mechanism, suggested in the HHS draft proposal, would cause Medicare capital reimbursement losses as follows:

- over $1.6 million on average annually during phase-in for University Hospital and over $4 million annually for University Hospital thereafter
- over $4.7 million on average annually for the six hospitals in aggregate during the seven-year phase-in
- over $14 million annually for the six hospitals in aggregate after full implementation

As shown in Table 1, these six hospitals would experience in total an estimated $32.7-million reimbursement shortfall over seven years under the HHS proposal. This shortfall was calculated assuming a national capital/operating cost ratio of 7.4 percent and without reduction for income from funded depreciation. Further reductions in the national rate will increase the losses to the teaching hospitals.

These resulting losses demonstrate the unreasonableness of the proposed system, in that its incentives and penalties are not based on a given hospital's efficiency. In fact, the six Boston teaching hospitals are highly efficient--with average 1985 occupancy over 84 percent (compared to a 1984 national average of 69 percent)--and provide high quality, high intensity care to large numbers of Medicare patients (approximately 45,000 in 1985).

Although it is difficult to predict the effects of the proposed system, there are likely to be unintended consequences. Most notable among these are the possible damage to bondholders and the resulting increased interest costs of future hospital capital investments. Table 2 shows projected interest and principal requirements for University Hospital and the additional five Boston tertiary teaching hospitals, based upon the published and/or supplied data.

The largest losses caused by the proposed system will accrue to hospitals with younger assets. Generally, these are hospitals that have recently made major capital investments and therefore have high levels of bond or mortgage debt with fixed obligations. The large losses to be experienced by Boston teaching hospitals with recent capital investments may make it difficult for them to meet their fixed debt payments, thereby endangering the investments of bondholders and mortgage investors throughout the country. In turn, the increased risk to debt holders may result in lower bond ratings and increased interest rates for future investments.

There may be other unexpected and unintended consequences. Because their capital costs are fixed, some hospitals will be forced to resort to cuts in operating expenses, which could significantly diminish the quality of care or range of services to Medicare patients. On the other hand, some hospitals with older facilities may receive payments that may help them resist economic pressures to improve or close despite low occupancy rates and inefficiencies.

IV. CONCERNS AND PROPOSED SOLUTIONS

The analysis conducted by University Hospital has led to three broad concerns that we believe prevent the proposals from meeting their stated goals:

1. Current proposals fail to meet the special and necessary additional capital costs incurred by tertiary teaching hospitals.

Analysis of Capital Reimbursement Proposals Projected Losses in Reimbursement for Six Boston Teaching Hospitals*

Table 1

	1987	1988	1989	1990	1991	1992	1993	1994	1995
	(In Thousands)								
University Hospital	$ 34	($265)	($ 830)	($1,477)	($2,102)	($2,931)	($ 3,751)	($ 4,146)	($ 4,122)
Other Five Teaching Hospitals	(194)	(391)	(737)	(2,826	(3,586)	(4,824)	(8,836)	(9,880)	(10,335)
	($160)	($656)	($1,567)	($4,303)	($5,688)	($7,755)	($12,587)	($14,026)	($14,457)
Range:									
High	$(128)	$(265)	$(830)	$(1,477)	$(2,102)	$(2,931)	$(5,940)	$(6,685)	$(7,130)
Low	$ 34	$ 71	$ 153	$ 182	$ 619	$ 930	$ 996	$ 904	$ 651

Projected Principal and Interest Requirements for Six Boston Teaching Hospitals

Table 2

	1987	1988	1989	1990	1991	1992	1993	1994	1995
	(In Thousands)								
University Hospital	$ 986	$ 7,523	$ 9,354	$ 9,482	$ 9,442	$ 9,439	$ 9,442	$ 9,443	$ 9,442
Other Five Teaching Hospitals	38,827	38,830	37,951	46,720	46,740	45,044	50,195	51,175	49,945
	$39,813	$46,353	$47,305	$56,202	$56,182	$54,483	$59,637	$60,618	$59,387
Range:									
High	$9,658	$10,183	$10,181	$16,713	$15,774	$15,874	$21,668	$22,032	$22,397
Low	$ 986	$3,954	$3,216	$2,932	$3,954	$2,222	$1,652	$2,349	$1,179

*Based on Department of Health and Human Services proposal of October 1985.

2. Current proposals do not allow adequate time for hospitals with high levels of fixed debt payments to make the adjustment to a uniform national rate.

3. As a result of the timing issue, current proposals apportion gains and losses on the basis of existing capital investment levels, rather than efficiency.

The following sections elaborate on these concerns and propose methods by which they can be resolved.

A. THE SPECIAL NEEDS OF TERTIARY TEACHING HOSPITALS

A major problem with the current proposals is that, by limiting capital reimbursement to average costs, they fail to recognize the legitimate above-average capital costs of the tertiary teaching hospital. These costs are inherent in the high-intensity patient care, state-of-the-art technology and medical training functions that take place in tertiary teaching hospitals. Failure to recognize these legitimate costs may damage these essential services. The current graduate medical education reimbursement methodology specifically excludes the capital costs for medical education.

The greater capital dependency of tertiary teaching hospitals arises from the need for larger plant size and from greater equipment needs. Tertiary teaching hospitals require more space per patient bed than a community hospital in order to accommodate additional bedside equipment, educational functions, and more professional personnel. In addition, the greater casemix intensity of tertiary hospitals increases the need for isolation rooms, intensive care facilities and specialty treatment and operating rooms.[4]

Tertiary teaching hospitals also generally have a broader and more comprehensive range of on-site equipment, caused, in part, by the initiatives of the health planning process and the need of teaching hospitals to maintain state of the art equipment. Additionally, because of the higher use rates of high-technology equipment in tertiary teaching hospitals, there is a higher level of obsolescence, increased equipment turnover and higher total capital costs.

These additional capital expenses are legitimate and necessary to maintain the clinical and educational functions of tertiary teaching hospitals; for these institutions to remain viable, such costs must be

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4 The Association of American Medical Colleges has demonstrated a 57-percent higher level of capital costs per work load unit (adjusted admission) in teaching hospitals. James O. Bentley, Toward an Understanding of Capital Costs in COTH Hospitals, March 27, 1984.

recognized and reimbursed by the Medicare system. Therefore, University Hospital recommends that any new Medicare capital reimbursement mechanism under PPS be modified to assure an adjustment that adequately reimburses the capital costs of teaching hospitals. This is particularly important since the current graduate medical education add-on does not incorporate the capital cost element. Reimbursement for teaching costs must include the capital costs associated with graduate medical education programs.

RECOMMENDATION: Provide an adjustment to compensate teaching hospitals for their added capital needs. We recommend an increase in the formula of 1 to 2 percent.

METHOD: An adjustment should be paid to tertiary teaching hospitals to allow a given percentage of additional costs, based on the number of residents (Full Time Equivalents) per bed. The appropriate adjustment could be 1 to 2 percent.[5] This proposal has the advantage of ease of administration; once initial levels are established, it can be administered as part of the current Graduate Medical Education add-on calculation. Moreover, this proposal does not increase aggregate Medicare expenditures on capital costs; rather, it redistributes the same payments on a basis that is more equitable and reflects the quality and intensity of care provided by these hospitals.

B. VARIATIONS IN THE CAPITAL CYCLE

University Hospital recognizes the need to incorporate capital into the Medicare Prospective Payment System. The current proposals, however, do not give adequate consideration to the extreme hardship inherent in the process of making the transition from cost-based reimbursement to a uniform national rate. As written, the proposals apportion gains and losses to hospitals based on the timing of capital construction and investment, forcing losses onto newer facilities regardless of efficiency. Unless current proposals are substantially modified to smooth this transition, the shift to the proposed system will cause serious and protracted payment problems for University Hospital, similar hospitals, and their associated bondholders.

The current proposals threaten to harm hospitals substantially because, unlike their control of operating costs, most hospitals have little control over capital costs in the short-run. Hospitals with substantial debt financing--especially those employing long-term bonds--are often contractually bound into 25- to 35-year fixed repayments. Consequently, hospitals with substantial levels of debt financing will be unable to make reductions in capital costs to respond

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5 The aforementioned study of capital costs in teaching hospitals and nonteaching hospitals by the Association of American Medical Colleges (March 27, 1984) on estimated capital costs per admission is the basis of this adjustment estimate.

to reduced Medicare capital reimbursement. In many cases, such hospitals will be forced to absorb multimillion dollar losses annually.

This problem is most damaging to hospitals that have recently incurred large amounts of debt to finance new capital projects. These are frequently the hospitals with the highest capital costs; yet because of the long-term nature of their bond issues, these hospitals are also the least able to exercise capital cost control. Once an institution has made multimillion investments in plant and equipment--and incurred substantial long-term debt--management cannot turn back. Yet these hospitals will face substantial cutbacks in Medicare capital payments under the proposed system.

University Hospital at Boston University Medical Center serves as a prime example of this problem. In 1984, after years of conservative spending for fixed assets (UH's aggregate asset age is between 12 and 40 years, depending on the measure used), UH received approval from the state's Determination of Need Program to begin a major capital construction and renovation project. A partial replacement building, scheduled to open in January, 1988, is financed by a 35-year, $76.9-million bond issue, with fixed interest and principal payments scheduled through the year 2019.

Because of the age of its facilities, UH has been able to maintain relatively low capital costs--and capital reimbursement. In 1988, when its replacement building opens, UH will experience a significant increase in capital costs; under the currently proposed mechanisms, however, UH will not be able to recoup Medicare's full share of these capital costs. This will result in a loss to UH of over $4 million annually after the HHS proposed seven-year transition period (see Table 1).

RECOMMENDATIONS: UH offers two alternative recommendations to ameliorate the problems that a uniform Medicare capital add-on will cause hospitals with new major capital projects--and their bondholders. One alternative deals with the length of the phase-in period; the second addresses the level of fixed debt.

1. Length of Phase-In Period: University Hospital proposes that the length of the period for phase-in to the uniform capital payment be extended for those hospitals with substantial debt financing. To implement this approach, a schedule would be established specifying varying lengths of phase-in based on the individual hospitals' amount of long-term debt as a percentage of total assets. Hospitals with very high percentages of debt financing would be allowed a longer adjustment period, commensurate with the length of bond commitments. For example, an appropriate period of time might be 12 to 15 years, for the most recent capital additions, or half the average time remaining on outstanding major bond commitments. To assure that this approach does not inappropriately protect inefficient hospitals, Congress could make this extended phase-in contingent upon a hospital's achievement or maintenance of high occupancy rates.

While this recommendation would not eliminate all losses caused by the transition to a uniform capital payment under prospective reimbursement, it would smooth the transition and diminish underpayments/shortfalls experienced by hospitals with newer facilities. At the same time, the majority of hospitals will be able to make the more rapid transition into the uniform capital rate.

2. Fixed Debt Payment Index: This recommendation would index Medicare rates to an individual hospital's level of outstanding fixed debt. We recommend that the capital payment be multiplied by an index with a value greater than one but not greater than the value providing full cost replacement for the hospital-specific portion. Hospitals with high levels of fixed debt would receive increased reimbursement to compensate for their higher capital costs. To eliminate incentives for new spending and allow for a natural phase-out of this transitional mechanism, Congress could specify that debt incurred after a certain date (e.g., 1986) would not be eligible for consideration as "fixed debt".

   The major advantage of this recommendation is that it would apportion greater payments to those hospitals that have contractually fixed costs and are therefore less able to respond rapidly to the changing environment. In addition, this recommendation would be relatively easy to administer and would rationalize incentives involved in capital spending.

Both of the above recommendations are specifically designed to enable the hospitals to meet existing commitments to bondholders. As shown in Table 2, the six Boston tertiary teaching hospitals alone have projected interest and principal payments primarily to bondholders of $360 million during the next seven years, with significant amounts thereafter. We believe that the mechanism incorporating capital costs into the Prospective Payment System must provide for existing commitments to bondholders.

VII. CONCLUSION

In conclusion, University Hospital finds that the current proposals do not meet their stated objectives for three reasons. First, they fail to recognize the additional capital investments required by tertiary teaching hospitals. Second, the proposals do not allow hospitals adequate time to adjust to a new reimbursement system. Third, the timing issues create unintended and counterproductive results by putting hospitals with younger assets (regardless of efficiency and occupancy) in economic straits to which they will be unable to respond, and similarly by providing potential extra benefits to hospitals with older assets (again regardless of efficiency or occupancy). Consequently, Boston tertiary teaching hospitals will experience substantial reimbursement losses--despite the high occupancy rates of these institutions.

Our concerns are directed by the resources needed by tertiary teaching hospitals to provide superior medical service, education, training and research. In addition, we seek to prevent unintended economic problems for hospitals with high fixed-asset levels that cannot be modified in short time frames. University Hospital at Boston University Medical Center is firmly convinced that adoption of its recommendations on capital will ameliorate potential problems of teaching hospitals as well as other hospitals and help ease the difficult transition to a new reimbursement system.

EXHIBIT 1

PROFILE OF SIX BOSTON TEACHING HOSPITALS

In 1983, six Boston teaching hospitals commissioned a study by Coopers & Lybrand to profile the services, financial characteristics and economic impacts of an aggregated entity, the "Six Boston Teaching Hospitals." Five of the hospitals studied for this analysis were represented in the 1983 study. The attached Profile is included to offer a concise summary of the scientific and medical advances initiated in Boston's tertiary teaching hospitals.

Six Boston Teaching Hospitals

A profile of the services, financial characteristics, and economic impacts of "Six Boston Teaching Hospitals," based on a study commissioned by:

Beth Israel Hospital
Brigham & Women's Hospital
The Children's Hospital
Massachusetts General Hospital
New England Medical Center
and
University Hospital at Boston University Medical Center

Study conducted by:
Coopers & Lybrand
Study Overview prepared by the sponsors

December, 1984

INTRODUCTION

Public scrutiny of America's hospitals has heightened out of concern over the costs of health care and the appreciation that we are in a time of dramatic change in both the delivery and financing of care as well as in its technological sophistication. Teaching hospitals are being challenged additionally to delineate the value of their teaching, training, and research programs, and their innovation and aggregation of specialized technology. Responding to these concerns, six major teaching hospitals in Boston commissioned a study to identify their collective impact in the City of Boston, the Commonwealth of Massachusetts, and beyond. The six hospitals are Beth Israel Hospital, Brigham & Women's Hospital, The Children's Hospital, Massachusetts General Hospital, New England Medical Center, and University Hospital at Boston University Medical Center. Located in the City of Boston and holding key affiliations with Boston medical schools, each is voluntary and nonprofit, provides general acute-care services to a wide range of the city, state, and national communities, and offers extensive teaching to medical students, training to resident physicians, and continuing education to established practitioners. Each conducts a sizeable sponsored research program responsible for advances in diagnosis and therapy that are of international renown and major human and economic significance.

The study aggregates audited financial information and supplemental financial, operational, and employment data from the six hospitals to present the collective impact of a consolidated entity, "Six Boston Teaching Hospitals." The detailed report presents the patient-care, research, and educational achievements of the six hospitals; summarizes aspects of their patient-care activities; and reviews their financial characteristics alone and in comparison with other hospitals in the Commonwealth and the nation, and with other industries.

The unquestionable major economic impact of the Six Boston Teaching Hospitals may surprise some readers. The impact of the hospitals on the area's businesses is as noteworthy as is their influence on health care. This economic impact must be taken into account as regulation from without and competition from within evolve in response to the changing environment of health care financing and delivery.

Collectively and individually, the Six Boston Teaching Hospitals have a nearly 200-year heritage of consistent excellence in patient care, in the education and training of health professionals, and in medical research. The study examines these institutions in terms of economic impact, service provided, and quality of management.

ECONOMIC IMPACT

The six hospitals exercise a profound economic impact, in both the City of Boston and the Commonwealth of Massachusetts, in terms of employment, goods and services purchased, the care provided to the medically indigent, and the substantial

economic and human resources attracted from outside the Commonwealth. Collectively, the Six Boston Teaching Hospitals * --

- employ 27,500 persons, of whom 15,000 live in Boston (1,800 are physicians). These 15,000 represent 5.7 percent of all employed Boston residents. Eighteen percent of all employees are members of minority groups.
- have a payroll of over one-half billion dollars, of which $370 million is directed to Boston residents.
- pay $183 million in employment taxes (federal, state, and FICA).
- purchase goods and services of $387 million, most of it from businesses in Boston and Massachusetts.
- attract sponsored research funds, primarily from the federal government, foundations, and national and international industry. In 1983, the total of such awards was $127.5 million, a 42-percent increase over the 1980 level. At the six teaching hospitals, more than 3,500 researchers and staff are employed in these efforts alone.

In addition, the six teaching hospitals provided $57.1 million in "uncompensated care" in 1983, which is 26 percent of the uncompensated care provided by all Massachusetts hospitals. (Uncompensated care represents the free care provided to

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* Data based on 1983 information

patients who are unable to pay, as well as any bad debts.) The figure excludes the discounts provided Medicare, Medicaid, Blue Cross, and certain other third-party payers. Most of the free care and bad debts derive from care provided the medically indigent or others who cannot pay for hospital services, many of whom are Boston residents. Uncompensated care is actually paid for by those few who pay somewhat more than cost, and also from hospital philanthropy and hospital endowment interest. If these three sources were not available, much of the burden would inevitably shift directly or indirectly to Massachusetts business and industry.

SERVICES PROVIDED

Patient Care: Collectively, the Six Boston Teaching Hospitals provide a comprehensive array of clinical services, with 3,470 beds including 362 devoted to intensive care. Bed utilization tends to be higher than that of most community hospitals, reflecting the role of these Boston institutions as "court of last resort" for the most complex and problematic cases. This responsibility is reflected in the relative growth of intensive care beds: While total bed complement of the six hospitals has grown less than one percent since 1981, the complement of intensive care beds grew by seven percent, through conversion of existing standard medical/surgical beds and addition of newborn intensive care bassinets. Reflecting that shift in facilities is a slight decline in patient days (excluding intensive care), from 1,033,957 days to 1,017,654 days or 1.64 percent from 1981 to 1983, while intensive care days increased by 10.16 percent, from 94,440 days to 104,039 days in

the same period. The wide service area is illustrated by the fact that only about one-third of inpatients are Boston residents, while about 57 percent reside elsewhere in Massachusetts and another 12 percent are residents of other states and countries. There is also a strong community focus, however, best seen in the ambulatory care and outreach programs. In 1983, over a million hospital-based clinic visits were recorded and an additional 270,000 visits were made to related nearby off-site clinics and community health centers. These six teaching hospitals provide 14.2 percent of all inpatient admissions and 12.4 percent of all hospital outpatient visits in Massachusetts.

Training: The Six Boston Teaching Hospitals offer 342 approved physician training programs in conjunction with the three Boston medical schools, including virtually every category of graduate training approved by the American Medical Association, the American Dental Association, and various specialty organizations. More than 1,600 interns, residents, and fellows were engaged in these programs in 1983. Thirty schools of nursing were affiliated with the six hospitals in that same year, involving the preparation of more than 1,100 registered nurses and 75 licensed practical nurses. More than 70 additional allied health training programs are in operation, training for such roles as physical therapist, occupational therapist, x-ray technician, and emergency medical technician; 720 students were involved in these programs in 1983. Ongoing educational programs fill the day at all six institutions for the benefit of both hospital-based medical staff and practitioners in the community; it is here in the major teaching hospitals that standards of care are established, monitored, and continually updated and refined.

OPERATING MANAGEMENT

In an increasingly restricted economic environment, the Six Boston Teaching Hospitals have continued to provide services of the desired quality and quantity, largely through strengthened administrative and clinical efficiency of operation. For example, in a regulatory environment allowing only a limited operating margin, the six hospitals have been replacing aging physical plants, a critical necessity given the high-technology services needed for the tertiary-care, referral patient. The six hospitals have led the way in the effective Massachusetts cost-control effort under Chapter 372. In several instances, better-than-expected bottom lines resulted from both stringent management operating controls in response to Chapter 372, and the lower-than-anticipated rate of inflation of the hospitals' expenses in the first years of operation of Chapter 372.

WHAT OF THE FUTURE?

The future poses serious challenges to the financial integrity of the Six Boston Teaching Hospitals, above and beyond the general risks for all Massachusetts hospitals.

- The regulated "productivity factor" reductions of seven percent ordained through 1988 by Chapter 372 will erode current operating margins. Representing (in 1983 dollars) some $70 million in revenue reductions, this factor will compromise the capability of these institutions to develop the "seed money" to establish new clinical programs, including new efforts for the poor. Nonoperating revenue sources are unlikely to cover anticipated shortfalls.

- As the bottom line wanes, access to capital will become increasingly restricted. Present superior credit strength may decline and interest rates on borrowed money may rise.
- The combination of more stringent regulation of payment for care and increased economic competition seems inevitable. These conflicting trends will be made even worse by a growing severity -- perhaps even arbitrariness and clinical irresponsibility -- of externally imposed utilization management controls designed to yield additional cost reductions. As operating flexibility becomes increasingly constricted, further curtailment of the expense budget will forebode a decline in quality of care, diminution of the specialized services which have placed these hospitals among the nation's leaders, and significant erosion of their employment and purchasing power. The balance of interests that shape these teaching hospitals' programmatic roles must therefore forge both the financial restraints and the encouragements that will direct them to meet fairly the responsibilities they have thus far fulfilled. To do so requires the understanding and support of a knowledgeable community. The alternative is a loss of those very qualities that help attract businesspeople to this Commonwealth.